Provider Manual - Combined

The information provided is the most up-to-date as of the date of this publication. For the most up-to-date information, visit providerlibrary.healthnetcalifornia.com

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Provider Manual

The Medicare Advantage (MA) Provider Operations Manual covers the Dual Special Needs Plan as well.

The Wellcare By Health Net (Health Net) Operations Manual offers Health Net providers access to important plan benefits, limitations and administration processes to make sure members enrolled in MA plans receive covered services when needed. The Plan's MA HMO plans are underwritten by Health Net of California, Inc. and Health Net Community Solutions, Inc (Health Net) and are regulated by the Centers for Medicare & Medicaid Services (CMS) and the California Department of Managed Health Care (DMHC).

Benefits and policies listed in the MA Operations Manuals apply to all Health Net MA plans unless specified otherwise in the Provider Participation Agreement (PPA), Schedule of Benefits or member's Evidence of Coverage (EOC).

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

As a Plan participating provider, you are required to comply with applicable Medicare laws and regulations and Plan policies and procedures.

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

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

Overview

A

- Acupuncture

- AIDS
- Alcohol and Drug Abuse
- Allergy Treatment
- Ambulance

B

- Bariatric Surgery
- Behavioral Health
- Blood

C

- Chemotherapy
- Chiropractic
- Clinical Trials
- Complementary Supplemental Benefits
- Cosmetic and Reconstructive Surgery

D

- Dental Services
- Dialysis
- Durable Medical Equipment

E

- Enteral Nutrition

F

- Family Planning

G

- General Benefit Exclusions and Limitations

H

- Hearing
- HIV Testing and Counseling
- Home Health Care
- Hospice Care
- Hospital and Skilled Nursing

I

- Immunizations

- Initial Health Assessment
- Injectables

J

K

L

M

- Maternity
- Medical Social Services

N

- Nurse Midwife

O

- Obesity
- Outpatient Services

P

- Physicians Visit
- Podiatry
- Post Stabilization
- Preventive Services
- Prosthesis

Q

R

- Rehabilitation Therapy
- Respite Care
- Routine Physical Exam

S

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

T

- TMJ
- Transgender Services
- Transplants
- Transportation

U

V

- Vision

W

X

- X-Ray and Laboratory Services

Y

Z

Overview

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

In accordance with the Centers for Medicare and Medicaid Services (CMS), Health Net and its participating providers must provide covered benefits in a manner consistent with professionally recognized standards of health care.

Services listed in the Benefits section provide general information regarding covered benefits for Health Net's Medicare Advantage (MA) plans. In all instances where the benefit information differs from the Provider Participation Agreement (PPA) and MA Addendum, the PPA and MA Addendum take precedence.

Acupuncture

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

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

Select any subject below:

- Acupuncture Services
- Covered Services

Acupuncture Services

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

Supplemental coverage for acupuncture services is available to some Health Net members. If members are unsure of their benefit coverage, they should be advised to contact the Health Net Member Services telephone number as listed on their identification (ID) cards.

Health Net members may quality for acupuncture services in one of two ways:

1. Enrolling in a medical plan that offers the option to purchase additional supplemental benefit coverage.
2. Enrolling in a medical plan that includes supplemental benefit coverage with their monthly plan premium.

Members who have this supplemental coverage obtain acupuncture services through the American Specialty Health Plans, Inc. (ASH Plans) network of participating acupuncturists without a referral from the member's primary care physician (PCP) or participating physician group (PPG).

If a member requests coverage for acupuncture services, and the member qualifies for acupuncture coverage under Health Net's arrangement with ASH Plans, refer the member to the employer, the Health Net Member Services Department or the Health Net Medicare Programs Member Services Department.

Coverage Exclusions and Limitations

The following items and services are limited or excluded under the acupuncture services benefit:

- All auxiliary aids and services, including but not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids
- Lab tests, X-rays and other treatments not documented as medically/clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If American Specialty Health Plans, Inc. (ASH Plans) denies coverage for therapy for a member who has a life-threatening or seriously debilitating condition based on a determination by ASH Plans that the therapy is experimental or investigational, the member may be able to request an external, independent review through the ASH Plans' Member Services Department
- Prescription and over-the-counter drugs
- Durable medical equipment (DME)
- Educational programs, non-medical self-care, self-help training or any self-help physical exercise training or any related diagnostic testing

- Acupuncture services that are considered experimental, investigational or unproven. Services that meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans determine is considered experimental, investigational or unproven
- Charges for hospital confinement and related services
- Charges for anesthesia
- Hypnotherapy, sleep therapy, behavior training and weight programs
- Services provided by acupuncturists who do not contract with ASH Plans, except with regard to emergency acupuncture services or upon referral by ASH Plans
- Only acupuncture services that are listed under the Acupuncture Services topic in the member's Evidence of Coverage (EOC) are covered. Unlisted services, which include, without limitation, services to treat asthma and services to treat any addiction, including treatment for smoking cessation, are not covered
- Services provided by an acupuncturist practicing outside California, except with regard to emergency acupuncture services. Note: No prior authorization is required for emergency acupuncture services. ASH Plans determinations to deny coverage for emergency acupuncture services may be appealed to Health Net
- The diagnostic measuring and recording of body heat variations (thermography)
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered. Other services, including, without limitation, ear coning and Tui Na, Ear coning, also called ear candling, involves the insertion of one end of a long, flammable cone into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also called Oriental Bodywork or Chinese Bodywork Therapy, utilizes the traditional Chinese medical theory of Qi but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture

Covered Services

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

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

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

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

AIDS

Provider Type: Physicians | 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/HIV Injectable Medication

AIDS/HIV Injectable Medication

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

AIDS/HIV injectable medications are injectable medications that have been approved by the U.S. 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.

Rapid Screening Tests

Health Net covers both standard and U.S. Food and Drug Administration (FDA)-approved HIV rapid screening tests for at-risk individuals.

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:

- Co-Management Process
- Coverage Explanation
- Referral Process
- Substance Abuse Facilities
- Substance Abuse Rehabilitation Services

Co-Management Process

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

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

Coverage Explanation

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

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

Medicare Advantage (MA) also cover alcohol and drug or substance abuse rehabilitation in inpatient and outpatient substance abuse facilities that are Medicare-certified. This includes institutional charges for inpatient substance abuse treatment programs and institutional and professional charges for day care substance abuse treatment programs. Refer to the member's Evidence of Coverage (EOC).

Referral Process

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

For referrals, contact Behavioral Health Provider Services.

Substance Abuse Facilities

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

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

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

Substance Abuse Facilities - Outpatient

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

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

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

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

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

- Professional and other trained staff and ancillary services provided in the facility that are necessary for treatment of the ambulatory patient.
- Individual and group therapy or counseling.
- Family counseling, with each visit by one or more family members of the Health Net member being deducted from the member's outpatient behavioral health consultation benefit for the calendar year.
- Laboratory tests required in connection with the treatment received at the facility.
- Medications, biologicals, solutions, and supplies dispensed by the facility in connection with treatment received at the facility, including medications to be taken home.

- Psychological testing by a person legally qualified to administer and interpret such tests. Where there are no licensure laws, the psychologist must be certified for psychological testing by the appropriate professional body (subject to prior review for medical necessity).

Substance Abuse Rehabilitation Services

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

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

Substance Abuse Rehabilitation Exclusions and Limitations

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

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

Allergy Treatment

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

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

Ambulance

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

This section contains general member benefit information on ambulance services.

Select any subject below:

- Ambulance Services
- Authorization
- Ambulance Services - No Transport
- ModivCare
- Transfer of Members Hospitalized Out of Area

Ambulance Services Medicare

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

Ambulance services are covered in an emergency or if the services are ordered and approved by a participating provider and are medically necessary under Medicare guidelines.

Ambulance services in conjunction with emergency medical treatment outside the participating physician group (PPG) or participating provider's service area are considered reinsured services. Services originating outside the PPG or participating provider's service area and terminating inside it are also considered reinsured services.

Authorization

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

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

Ambulance Services - No Transport

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

The following shows the Medicare Advantage coverage determination for various ground ambulance scenarios in which the member expires. In each case, the assumption is the ambulance transport would have otherwise been medically necessary.

Ground Ambulance Scenarios: Member Death

Scenario	Coverage Determination
Time of Death Pronouncement (by an individual authorized by the state to make such pronouncements)	Medicare Payment Determination
Before dispatch	The service is not covered
After dispatch, before member is loaded onboard the ambulance (before or after arrival at the point-of-pickup)	The provider's or supplier's basic life support (BLS) base rate, no mileage or rural adjustment; use the QL modifier (member died after ambulance was called) when submitting the claim
After pickup, prior to or upon arrival at the receiving facility	Medically necessary level of service furnished

Transfer of Members Hospitalized Out of Area

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

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

Modivcare

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

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

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

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

Bariatric Surgery

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

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

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

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
- 5150 Holds
- Continuity of Care

- General Guidelines for Referrals

Overview

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

Most Wellcare By Health Net (Health Net) employer group and individual plan members obtain behavioral health and substance abuse services through Health Net.

Health Net MA-only and MA-PD members who access behavioral health services do not need to contact their primary care physician (PCP), participating physician group (PPG) or attending physician to request a referral for behavioral health care or substance abuse services. Instead, Health Net MA-only and MA-PD members obtain these services directly through Health Net's extensive behavioral health and substance abuse network.

Health Net participating providers may also refer members for routine behavioral health services by calling Behavioral Health Provider Services.

Refer to the Schedule of Benefits or member's Evidence of Coverage for specific benefit information.

For members on a Dual Special Needs Plan (D-SNP), their Medicare benefits are primary. D-SNP members also have Medi-Cal covered behavioral health benefits available through specialty Mental Health and Substance Use Disorder Services through Medi-Cal fee-for-service.

5150 Holds

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

Under Section 5150 of the California Welfare and Institutions Code, a person who may be dangerous to self or others can be taken into custody and placed in an approved facility for a 72-hour treatment and evaluation. This is commonly referred to as a "5150 hold." Inpatient psychiatric coverage applies. 5150 holds are considered emergencies and should be handled like any other emergency inpatient hospitalization where the member cannot be immediately transferred. If the member is admitted to a non-participating facility and cannot be transferred until the 72-hour hold has expired, the situation should be monitored by Health Net. If continued inpatient care is required, the member should be transferred to a participating facility when it is safe to do so. Prior authorization is not required for emergency care; however, providers are encouraged to contact Health Net to report emergency encounters and admissions, and to coordinate post-stabilization care.

Continuity of Care

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

Health Net offers continuity of care assistance for new Health Net members who are receiving care from a out-of-network practitioner for a current episode involving an acute, serious or chronic mental health condition. This determination takes into consideration the potential clinical effect on a member's treatment due to a provider change. If authorized, Health Net allows the member a reasonable transition period (subject to the benefit limit) to continue their course of treatment with the non-participating practitioner prior to transferring to a participating practitioner. Health Net authorizes services according to state and federal regulation.

Practitioners or Health Net members may request continuity of care assistance by contacting Health Net directly. Health Net customer service representatives obtain the information necessary to authorize care and then refer the call to a Health Net care manager. Care managers are licensed behavioral health professionals who authorize services and consult as needed with Health Net physician advisors. Health Net notifies the requesting practitioner, or Health Net member by phone of the continuity of care decision. Providers may print the Quick Reference Sheet (PDF) and hang it in their office for easy access to Health Net contact information.

Except for behavioral health and substance abuse services, all other covered services, including prescription medications, continue to be coordinated by the member's primary care physician (PCP). Providers treating members without behavioral health benefits should assess for behavioral health needs and refer as appropriate. Providers should consult with their participating physician group (PPG) for questions regarding participating behavioral health providers.

General Guidelines for Referrals

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

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

- Moderate to severe symptoms of depression that are not responding to treatment with first-line antidepressant medications.
- Suicidal ideation.
- Schizophrenic disorders where Clozaril® or risperidone or similar psychopharmaceuticals are being considered.
- Bipolar disorder where lithium, valproic acid, carbamazepine, or similar psychopharmaceuticals may be needed.
- Eating disorders.
- Psychological issues for outpatient referral, such as anxiety, phobias, stress, and depression.
- Transition of care from psychological to medical facility, such as a skilled nursing facility (SNF), or vice versa.
- Member is inpatient and a behavioral health provider is consulted or behavioral health services are ordered as part of the discharge plan.
- Alcohol or other substance abuse or dependence that is not responsive to brief interventions to reduce intake, motivational enhancement therapies and self-help programs, or those in need of detoxification.
- Transition from detoxification to medical bed.
- Psychiatric consultation, psychological/neuropsychological testing or psychiatric evaluation requested at a facility.
- Catastrophic illness requiring behavioral health support.
- Difficult placement due to medical and behavioral health problems.
- Pain management with substance abuse issues.

- Frequent emergency visits for behavioral health diagnoses or pain issues.
- Autism spectrum disorder.

Blood

Provider Type: Physicians | Participating Physician Groups (PPG)

Blood and blood plasma, and derivatives are covered.

This coverage includes all of the following:

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

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

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

Chemotherapy

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

This section contains general member benefit information on chemotherapy.

Select any subject below:

- Overview
- Off-Label Use
- Oral Anti-Cancel Medications
- Oral Anti-Emetic Medications

Overview

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

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

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

Off-Label Use

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

Off-label use of a medication is a use that is not included as an indication on the medication's label as approved by the Food and Drug Administration (FDA). FDA-approved medications used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice. In the case of medications used in an anti-cancer chemotherapeutic regimen, unlabeled uses are covered for a medically accepted indication as defined in the Medicare Carriers Manual, Section 2049.4.C.

Unlabeled use of FDA-approved medications and biologicals used in anti-cancer chemotherapeutic regimens for medically accepted indications are covered as described in the Medicare Benefit Policy Manual (100-02), Chapter 15 - Covered Medical and Other Health Services; 50.4.5 - Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (Rev. 96, Issued: October 24, 20014, Effective: June 5, 2008; NCCN/ 06-10-08 Thomson Micromedex/July 2, 2008, Clinical Pharmacology, Implementation: November 25, 2008).

Oral Anti-Cancer Medications

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

Oral anti-cancer medications are part of a member's prescription medication benefit and require a brand-name medication copayment. All anti-cancer medications are processed the same as regular prescription medications and the maximum annual benefit applies. To be covered, the oral anti-cancer medication must comply with the following:

- Be prescribed by a physician or other provider licensed to prescribe such medications as anti-cancer chemotherapeutic medications
- Be a Food and Drug Administration (FDA)-approved medication or biological
- Contain the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic medication or biological that is covered when furnished in incident to the physician's service. The oral anti-cancer medication and the non-self-administered medication must have the same chemical generic name as indicated by the FDA's Approved Drug Products (Orange Book), Physician Desk Reference (PDR), or an authoritative medication compendium
- Be a prodrug. A prodrug is an oral medication ingested into the body that metabolizes into the same active ingredient that is found in the non-self-administered version of the medication
- Be medically necessary for the member

Oral Anti-Emetic Medications

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

Section 4557 of the Balanced Budget Act of 1997 (BBA) extends the coverage of oral anti-emetic medications under the following conditions:

- Coverage is provided only for oral medications approved by the Food and Drug Administration (FDA) for use as anti-emetics
- Oral anti-emetic medications must either be administered by the treating physician or in accordance with a written order from the physician as part of a cancer chemotherapy regimen
- Oral anti-emetic medications administered with a particular chemotherapy treatment must be initiated within two hours of the administration of the chemotherapeutic medication and may be continued for a period not to exceed 48 hours from that time
- The oral anti-emetic medications provided must be used as full therapeutic replacement for the intravenous anti-emetic medications that would have otherwise been administered at the time of the chemotherapy treatment

Only medications prescribed pursuant to a physician's order at the time of chemotherapy treatment qualify. The dispensed number of dosage units may not exceed a loading dose administered within two hours of that treatment plus a supply of additional dosage units not to exceed 48 hours of therapy.

Oral medications that are not approved by the FDA for use as anti-emetics and that are used by treating physicians incidental to cancer chemotherapy are not covered or reimbursable.

A limited number of members will fail on oral anti-emetic medications. Intravenous anti-emetics may be covered (subject to medical necessity) when furnished to members who fail on oral anti-emetic therapy.

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
- Course of Treatment
- X-Rays

Course of Treatment

Provider Type: Physicians | Participating Physician Groups (PPG)

Medicare Advantage (MA) members receiving chiropractic services under Medicare-covered medical benefits should expect a course of treatment to affect improvement of, arrest or retard deterioration of a spinal joint condition within a reasonable period of time. Reasonableness depends on whether the subluxation is acute (for example, a strain or sprain) or if it is chronic (involving loss of joint mobility).

Although there are no chiropractic visit limits under the Medicare-covered benefit and the number of visits is determined by medical necessity, if the above criteria are met, up to 12 chiropractic treatments may be allowed without additional review. Additional services must be reviewed to determine the efficacy of therapy.

Coverage is excluded for most other diseases and pathological disorders, such as multiple sclerosis, pneumonia, emphysema, muscular dystrophy, and rheumatoid arthritis. These disorders do not provide therapeutic grounds for chiropractic manipulative treatment.

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

The following is chiropractic benefit information for Medicare-covered services and routine services (not covered by Original Medicare).

Chiropractic Services as Medical Benefits (Original Medicare Chiropractic Coverage)

Medicare Advantage (MA) HMO members have coverage for Original Medicare-covered chiropractic benefits of manual manipulation of the spine to correct subluxation of an acute condition. Prior authorization may be required, except in an emergency. Maintenance care is not considered by Medicare to be medically reasonable and necessary, and is not covered. For MA PPO members, authorization is not required for out-of-network services; however, the services must meet the requirements indicated in the Coverage Criteria section. Enrollees may also self-refer for out-of-network coverage.

Health Net and its delegated participating physician groups (PPGs) apply Medicare's coverage criteria when determining whether a referral to a chiropractor (or equivalent manipulative practitioner) 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.

Coverage Criteria

The primary diagnosis for chiropractic coverage must be subluxation. Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact. A subluxation may be demonstrated by an X-ray or physical examination.

Chiropractors must use the acute treatment (AT) modifier when billing chiropractic claims (CPT codes 98940, 98941, 98942) to identify services that are active/corrective treatment of acute or chronic subluxation, which are covered Original Medicare benefits.

Physical therapy is not equivalent therapy. Physical therapists cannot perform manual manipulation of the spine, which is the extent of Original Medicare-covered chiropractic services covered under the member's medical benefits.

Routine Chiropractic Services (Non-Medicare Covered Services) for MA HMO

Coverage for routine chiropractic services (non-Medicare covered services) is available to some Health Net HMO Medicare Advantage (MA) members as part of the Optional Supplemental Benefits Package or in some plans as a core supplemental benefit. Employer groups may purchase additional chiropractic care benefits through American Specialty Health Plans, Inc. (ASH Plans). All members with supplemental coverage must obtain routine services through ASH Plans' network of contracting chiropractors in accordance with the requirements of the Optional Supplemental Benefits Package.

Optional Supplemental Benefits Package

Routine chiropractic services are covered as part of the Optional Supplemental Benefits Package (s) administered by American Specialty Health Plans, Inc. (ASH Plans). Some members under an individual MA plan or the employer group have the option to purchase the benefits package for a monthly premium in addition to the member's monthly plan premium. Benefits and premiums vary by plan. Providers should refer to the member's Evidence of Coverage (EOC) to confirm specific coverage information exclusions, limitations and cost-sharing.

The Optional Supplemental Benefits Package may also include coverage for supplemental acupuncture and FitOn Health. Acupuncture benefits are administered by ASH.

Members may self-refer to an ASH Plans participating provider for an initial examination. Subsequent visits and treatment require approval by ASH Plans.

Exclusions and Limitations

The following is a list of exclusions and limitations applicable to the ASH Plans program for MA members. These benefits and services are not covered:

- Chiropractic services that exceed the maximum number of covered visits (combined with acupuncture services) as indicated in the EOC or per calendar year for each individual members
- Diagnostic radiology, including MRIs and X-rays
- Durable medical equipment (DME)
- Outpatient prescription medications and over-the-counter medications
- Educational programs, non-medical self-care, self-help training, and related diagnostic testing
- Hypnotherapy, sleep therapy, behavior training, and weight programs
- Services provided by an out-of-network provider that has not signed the Provider Acceptance (PAF) form, except with regard to emergency chiropractic services or upon a referral by ASH Plans
- Examinations or treatment for conditions unrelated to neuromusculoskeletal disorders, including physical therapy not associated with spinal, muscle and joint manipulation
- Services provided by chiropractors practicing outside California except with regard to emergency chiropractic services
- Services that are not within the scope of licensure for a licensed chiropractor in California
- The diagnostic measuring and recording of body heat variations (thermography)
- Transportation costs, including local ambulance charges
- Services or treatments that are not documented as medically necessary or services not authorized by ASH Plans
- Vitamins, minerals, nutritional supplements, or other similar products

X-Rays

Provider Type: Physicians | Participating Physician Groups (PPG)

Subluxation may be demonstrated by an X-ray or physical examination.

An X-ray is not covered if it is taken or ordered by a chiropractor. Neither the participating physician group (PPG) nor Health Net can refuse to authorize coverage of an X-ray taken solely to diagnose subluxation in order to support the need for chiropractic care as long as the X-ray is ordered, taken and interpreted by a doctor of medicine or osteopathy. Generally, Medicare Advantage (MA) members seeking chiropractic services have clinical indications that would support medical necessity for an X-ray or physical examination. If those indications are present, Maximus Federal Services (the Centers for Medicare and Medicaid Services' independent review entity) would likely overturn any denial.

If the member has an X-ray from any source that fulfills the coverage criteria, the member is entitled to a referral.

If an member is requesting an X-ray for what appears to be routine chiropractic care (non-Medicare covered), the member's primary care physician (PCP) should inform the member that these services are not covered under Original Medicare and that the member is financially responsible.

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:

- Original Medicare Coverage for Qualified Clinical Trials

Original Medicare Coverage for Qualified Clinical Trials

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

Original Medicare provides coverage for routine costs of qualifying clinical trials, as well as reasonable and necessary items and services to diagnose and treat complications arising from participating in all qualifying clinical trials. Medicare's clinical trial National Coverage Determination (NCD) defines routine costs and also clarifies when items and services are reasonable and necessary. Costs directly related to the experimental portion of the clinical trial are the responsibility of the institution conducting the research. If a Health Net Medicare Advantage (MA) member joins a clinical trial, the member is responsible for any coinsurance under Original Medicare.

Health Net pays the MA member the difference between Original Medicare cost-sharing incurred for qualified clinical trials and services and Health Net's in-network cost-sharing for the same category of items and services. This cost-sharing reduction applies to all qualified clinical trials.

To be eligible for reimbursement, the MA member (or provider acting on behalf of the member) must notify Health Net that they have received qualified clinical trial services and provide documentation of the cost-sharing incurred, such as the Medicare Summary Notice (MSN). If necessary, Health Net may seek the MA member's Original Medicare cost-sharing information directly from the clinical trial provider.

Health Net does not require prior authorization for a qualified clinical trial; however, Health Net should be notified prior to when a MA enrollee is participating in a clinical trial.

Clinical trial providers are not required to be Health Net MA participating providers. MA members continue to receive care for MA-covered services unrelated to clinical trials through their Health Net MA plan.

For specific information related to coverage for clinical trials, refer to Coverage of Clinical Trials on the Centers for Medicare and Medicaid Services' (CMS').

Investigational Device Exception (IDE)

CMS determines Medicare device coverage based on Food and Drug Administration (FDA) category. FDA-designated Category A investigational device exception (IDE) (IDEs that are experimental/investigational) studies are not covered by Medicare unless they are part of a qualifying clinical trial as described in the preceding section. Category B IDE (non-experimental/investigational) studies may be covered through local determinations made by the Medical Advisory Council (MAC). Health Net is responsible for payment of claims related to Category B IDE studies covered by the local MAC with jurisdiction over the MA plan's service area.

Complementary Supplemental Benefits

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

The following benefits may be included in the core medical benefits of some Health Net Medicare Advantage (MA) plans with no additional premiums (benefits vary by plan and by county):

- Acupuncture - routine care
- Chiropractic - routine care
- Routine eyewear
- Preventive dental (with no network restrictions)
- Preventive dental with coverage for fillings and non-surgical extractions (DPPO)
- Preventive and comprehensive dental combined (DHMO or DPPO)
- Non-emergent transportation (NET)
- Multi-Benefit Spendables Card (vendor is Solutran)
- FitOn Health fitness program
- Telehealth Services (vendor is Teledoc Health™)
- Personal Emergency Response Systems (vendor is VRI)

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
- Breast Cancer Reconstructive Surgery

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)

Breast reconstruction surgery is covered when performed after a medically necessary mastectomy or to achieve or restore symmetry after a medically necessary 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 is also covered when necessary to achieve a 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.

Dental Services

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

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

Select any subject below:

- Overview

Overview

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

Some Medicare Advantage members have basic and/or restorative dental coverage. For a comprehensive list of covered dental services for these members, refer to the member's Evidence of Coverage (EOC) or Schedule of Benefits. Although Dental Benefit Providers (DBP) administers the dental benefit for many Wellcare By Health Net plans, the vendor that administers the dental benefit is plan-specific.

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

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

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

Coverage Explanation

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

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

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

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

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

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

DENTAL SERVICES FOR D-SNP MEMBERS

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

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

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

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

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

Dialysis

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

This section contains general member benefit information on dialysis.

Select any subject below:

- CMS Notification of ESRD Members
- Out-of-Area Dialysis for ESRD
- Submission of Claims

CMS Notification of ESRD Members

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

Health Net covers end-stage renal disease (ESRD) dialysis services, including peritoneal and hemodialysis, prior to the member's eligibility for Medicare.

- Hemodialysis - is usually accomplished in three, four-hour sessions per week. It usually takes place in an outpatient dialysis center with trained staff assisting the member
- Peritoneal dialysis - usually takes place in the member's home, after the member and/or caregiver has completed an appropriate course of training

Health Net members with ESRD are eligible for primary Medicare coverage after completion of the 30-month coordination period following the start of dialysis.

The dialysis center is required to file an ESRD Medical Evidence Report (PDF), CMS-2728 with the Centers for Medicare and Medicaid Services (CMS) to register a member that has been diagnosed with ESRD.

Out-of-Area Dialysis for ESRD

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

Health Net provides benefits for dialysis services rendered when a member is temporarily outside the Health Net service area under the following conditions:

- When the emergency arises from accident, injury or illness
- Where the health of the member would be endangered if they traveled to return to the Health Net service area
- When it is customary practice in border communities for members to use medical resources in adjacent areas outside the Health Net service area

- When an out-of-area treatment plan has been proposed by the member's primary care physician (PCP) and the proposed plan has been received, reviewed and authorized before services are provided. Health Net may authorized such out-of-area treatment plans only when the proposed treatment is not available from resources and facilities with the Health Net service area

Before leaving the service area, members should contact Health Net's Member Services Department for assistance in coordinating dialysis services when out of area.

If a Medicare Advantage (MA) member has not moved from Health Net's service area, but has left the service area for more than six months, Health Net must disenroll the member from the Health Net MA plan.

Prior Authorization for Out-of-Area Dialysis

Health Net does not require prior authorization or advance notification for dialysis services as a condition of coverage when a member is temporarily absent from Health Net's service area.

For purposes of coordinating member care, Health Net requests that members inform their primary care physician (PCP), participating physician group (PPG) or Health Net when the member needs dialysis services while temporarily outside the provider's or Health Net's service area. Providers may offer medical advice and recommendations of Medicare-approved dialysis facilities in the area for the member. Health Net provides benefits to Medicare-approved dialysis facilities the member independently selects while temporarily outside the PCPs, PPGs or Health Net service area.

Out-of-Country Dialysis

Non-emergency dialysis received outside the United States is not covered. This includes all outpatient dialysis received by members presently diagnosed with end-stage renal disease (ESRD) and already receiving dialysis services.

Submission of Claims

Provider Type: Participating Physician Groups (PPG)

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

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

Durable Medical Equipment

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

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

Select any subject below:

- Overview
- Coverage
- Criteria for Apria Capitation
- Orthotics
- Service Providers

Overview

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

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

Ownership of DME Items

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

Repairs

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

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

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

Coverage

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

Durable medical equipment (DME), including respiratory equipment and wheelchairs as defined by Health Net using Medicare guidelines, is covered when determined to be medically necessary and ordered or approved through the participating physician group (PPG) or Health Net in accordance with policies established by the PPG, Health Net and Medicare.

To ensure appropriate coverage of medical services for Health Net members, Health Net requires that members be provided with timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in non-coverage of medical items or required coverage of unnecessary items.

Capitation is applicable to certain membership assigned to select PPGs. The Division of Financial Responsibility (DOFR) allows a PPG to participate in ancillary DME capitation with Apria Healthcare for most DME items.

DME benefits include but are not limited to:

- Braces - Orthopedic appliance or apparatus used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces, and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belts
- Canes
- Crutches
- Insulin pumps, when specific medical criteria are met. For more information, refer to Health Net's medical policy on insulin pumps, available on the Health Net provider website
- Orthopedic shoes, if they are an integral part of a leg brace
- Oxygen
- Seat lift (only the seat-lift mechanism is covered, not the chair itself); when specific medical criteria are met
- Custom footwear and custom shoe inserts; for members with diabetes and members with the extra foot orthotic benefit. Includes one pair of extra depth or custom molded shoes (including non-customized removable inserts provided with the shoes) and/or three pairs of inserts each calendar year
- Orthotics, as defined as rigid or semi-rigid device affixed to the body externally and required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body

- Walkers
- Wheelchairs, including manual and motorized vehicles
- Whirlpool bath equipment - Covered if member is homebound and has a condition for which the whirlpool bath would provide substantial therapeutic benefits. Requests are reviewed case-by-case
- Power-operated vehicle (POV) or scooter

Diabetic supplies

Health Net Medicare Advantage members can obtain diabetic supplies, including blood glucose test strips and lancets, through any Health Net network pharmacies. Diabetic supplies require a prescription.

For Medicare only, please note, certain Health Net Employer Group plans may have a different benefit start date. Contact Pharmacy Services for more details for Employer Group plans.

Health Net network pharmacies can provide the following preferred brands:

Blood glucose meters:

- **OneTouch® by LifeScan, Inc.**
  - OneTouch Verio Flex® Meter
  - OneTouch Verio Reflect® Meter
  - OneTouch® UltraMiniTM Meter
  - OneTouch® Ultra® 2 Meter
  - OneTouch® Verio Meter
  - OneTouch® Verio® IQ Meter
- **Accu-Chek® by Roche Diabetes Care, Inc.**
  - Accu-Chek® Guide Me Meter
  - Accu-Chek® Guide Meter
  - Accu-Chek® Aviva Plus Meter
  - Accu-Chek® Nano SmartView Meter

Test Strips:

- **OneTouch®:**
  - OneTouch Verio®
  - OneTouch Ultra®
- **Accu-Chek®:**
  - Accu-Chek® SmartView
  - Accu-Chek® Guide
  - Accu-Chek® Compact Plus
  - Accu-Chek® Aviva Plus

Note: All other non-preferred brand blood glucose meters and test strips require prior authorization. Continuous glucose monitoring systems and supplies require prior authorization.

An updated list of covered diabetes testing supplies can be found on our website.

Non-covered items include:

- Exercycles

- Elastic stockings, job stockings and support hose; garter belts and similar devices, as they are not considered braces
- Foot supportive devices, whether custom-made (orthotics) or stock pre-made (arch supports, inserts, heel and sole lifts, and heel wedges or pads), unless they are an integral part of a leg brace
- Ambulatory blood pressure monitoring with automatic or semi-automatic (patient-activated) portable monitors - Not covered for hypertensive members, but may be covered if prescribed by a physician for use as part of home dialysis delivery system
- Modification of automobiles/or other highway motor vehicles
- Books or other items of a primarily educational nature
- Air conditioners, air filters or heaters
- Food blenders
- Reading lamps, or other lighting devices
- Bicycles, tricycles or exercise equipment (generally)
- Televisions
- Orthopedic mattresses, recliners, rockers, seat lift chairs, or other furniture items
- Waterbeds
- Household items
- Other items not generally used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them

Coverage (Medicare Physicians)

Durable medical equipment (DME), including blood glucose monitors, test strips and lancets, as defined by Health Net using Medicare guidelines, is covered when determined to be medically necessary.

DME includes:

- Brace - Orthopedic appliance or apparatus used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belts
- Canes
- Crutches
- Blood glucose monitoring devices, if authorized. Blood glucose test strips and lancets are covered under the pharmacy benefit. Insulin-dependent and non-insulin-dependent diabetics may receive these supplies:
    - Members are offered blood glucose monitoring devices and supplies as listed in the Health Net Recommended Drug List (RDL). New members may change their current blood glucose monitoring device for one of the preferred brands at no charge
    - Medicare Advantage (MA) and Medicare Advantage Part D (MA-PD) members may obtain blood glucose monitoring equipment and supplies by contacting the Health Net Medicare Advantage (MA) Member Services Department. For Medicare Prescription Drug Plan (PDP) members, pharmacies should bill Medicare directly for blood glucose monitoring equipment and supplies

  For the MA population assigned to participating physician groups (PPGs) with ancillary capitation, glucose monitors are covered under ancillary capitation, since coverage is via the DME benefit.

- Insulin pumps; when specific medical criteria are met. Refer to Health Net's medical policy on insulin pumps, available on provider.healthnet.com, for more information

- Orthopedic shoes, if they are an integral part of a leg brace
- Oxygen
- Power-operated vehicle (POV) or scooter
- Seat lift (only the seat lift mechanism is covered, not the chair itself); when specific medical criteria are met
- Custom footwear and custom shoe inserts - For members with diabetes and members with the extra foot orthotic benefit. Includes one pair of extra depth or custom molded shoes (including non-customized removable inserts provided with the shoes) and/or three pairs of inserts each calendar year
- Orthotics, as defined as rigid or semi-rigid device affixed to the body externally and required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body
- Walkers
- Wheelchairs - Manual and motorized vehicles are included
- Whirlpool bath equipment - Covered if member is homebound and has a condition for which the whirlpool bath would provide substantial therapeutic benefits. Requests are reviewed case-by-case

Non-covered items include:

- Exercycles
- Elastic stockings, job stockings and support hose; garter belts and similar devices, as they are not considered braces
- Foot supportive devices, whether custom-made (orthotics) or stock pre-made (arch supports, inserts, heel and sole lifts, and heel wedges or pads), unless they are an integral part of a leg brace or the member is a diabetic or has the extra foot orthotic benefit
- Ambulatory blood pressure monitoring with automatic or semi-automatic (patient-activated) portable monitors - Not covered for hypertensive members, but may be covered if prescribed by a physician for use as part of home dialysis delivery system
- More than one piece of the same equipment at a time

Criteria for Apria Capitation

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

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

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

Apria services include, but are not limited to:

- Comprehensive continuous positive airway pressure (CPAP) services

- DME
- Enteral nutrition therapy
- Home oxygen equipment
- Negative pressure wound therapy

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

Orthotics

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

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

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

Service Providers

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

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

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

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

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

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

Enteral Nutrition

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

Medicare-covered parenteral and enteral nutrition (PEN) covers related supplies and nutrients. PEN does not cover baby food and other regular grocery products that can be pureed and used with the enteral system or any additional nutritional supplementation, such as those for daily protein or caloric intake.

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:

- Coverage Exclusions
- Infertility

Coverage Exclusions

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

Health Net Medicare Advantage (MA) does not cover family planning services that may include counseling by a physician to determine the number and spacing of a member's children through birth control or fitting and insertion of birth control devices. Family planning services are not covered, based on Medicare's exclusion of "not reasonable and necessary," for the diagnosis or treatment of an illness or injury.

Non-prescription contraceptive supplies and devices are not covered.

Infertility

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

Medically necessary services associated with treatment for infertility are covered. Reversal of sterilization procedures and conception by artificial means, such as in vitro fertilization (IVF), zygote intrafallopian transfers (ZIFT) and gamete intrafallopian transfers (GIFT), are not covered unless defined as covered in the *Evidence of Coverage (EOC)*.

General Benefit Exclusions and Limitations

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

The general coverage limitations are as follows:

- Any services not authorized through the member's selected participating physician group (PPG) in accordance with procedures established by the PPG, Health Net and Medicare are not covered (except for emergency or out-of-area urgently needed renal dialysis services; refer to the Emergency Services topic)
- Acupuncture
- Cosmetic services and supplies - The following services and supplies, irrespective of the purpose for which they are performed, are not covered: hair transplant, hair analysis, hairpieces, wigs and cranial/hair prosthesis, chemical face peels, abrasive procedures of the skin, liposuction of any body part, or epilation by electrolysis or other means

The following services are not covered except when required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body
- Surgery to reform or reshape skin or bone
- Surgery to excise or reduce skin, corrective or fatty tissue that is loose, wrinkled, sagging, or excessive on any part of the body

This limitation does not apply to breast surgery and all stages of reconstruction for the breast on which a medically necessary mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast is covered.

- Chiropractic care - Coverage for chiropractic services is limited to treatment by means of manual manipulation of the spine to correct subluxation, unless specifically listed in the member's Evidence of Coverage (EOC)
- Custodial or domiciliary care - Regardless of the type of facility, custodial and domiciliary care is not covered
- Dental services - Care or treatment of teeth and gingival tissues, extraction of teeth; treatment of dental abscess or granuloma, other than tumors, dental examinations, spot grinding, crowns, bridge work, onlays, inlays, dental implants, braces, and any orthodontic appliances are not covered unless specifically provided in the member's EOC
- Duplicate Health Net coverage - If the member is covered by more than one Health Net group plan, coverage is determined by applying provisions in the Coordination of Benefits topic
- Expenses before coverage begins - Services received before the member's effective date are not covered
- Expenses after termination of coverage - Services received after coverage is terminated are not covered
- Experimental or investigative procedures - All procedures generally recognized by the organized medical community and its societies and per Medicare guidelines as experimental or investigative, including services that are solely and explicitly related to these procedures (but not including medical complications relating to or arising out of such procedures), are not covered. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those

items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community. Participation in a clinical trial that meets Medicare requirements are covered for members with a diagnosis of cancer. Such members may enroll in a clinical trial program, which is administered by the Centers for Medicare and Medicaid Services (CMS) and is separate and distinct from their Health Net plan

- Hospice benefits - Any item or service which is included in the plan of care developed by a hospice and for which payment may be made under Medicare as necessary for the palliation and management of a terminal illness and related conditions is considered a hospice benefit. Hospice services and any other services relating to the member's terminal condition are not covered by Health Net under its Medicare Advantage (MA) plans to Medicare-entitled members. Such members may enroll in a Medicare hospice program, which is administered by the CMS and is separate and distinct from a Health Net MA plan. The member's attending physician or primary care physician (PCP) refers the member to a Medicare participating hospice if the member wishes to elect such coverage. If the member remains enrolled in a Health Net MA plan, the member continues to seek and receive all services and coverage unrelated to the member's terminal condition through the Health Net MA plan, the member's PPG or PCP
- Military service-connected disability - Diseases and disabilities rated by the U.S. Department of Veterans Affairs (VA) as being "service-connected disabilities" entitling members to benefits from the department, if the member obtains care through the VA
- Miscellaneous hospital expenses - Personal or convenience items, such as a telephone or television in the room at a hospital or skilled nursing facility (SNF), are not covered
- Non-covered items:
    - Disposable supplies for home use, including diapers, incontinence pads, plastic gloves, comfort items (for example, pillows, adjustable beds)
    - Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts exercise bicycles, free weights
    - Over-the-counter support appliances and supplies, such as stockings and arch supports, or ace bandages
    - Hearing aids - unless specifically provided in the Schedule of Benefits, EOC or approved by Health Net or the member's PPG
    - Contact or corrective lenses (except an implanted lens that replaces the organic eye lens, and one pair of eyeglasses or contact lenses following cataract surgery) and eyeglasses are not covered, unless specifically provided elsewhere in the member's EOC or under Medicare guidelines
- Non-eligible institutions - Any services or supplies furnished by a non-eligible institution, which is other than a legally operated hospital or Medicare-approved SNF, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated, are not covered
- Non-prescription birth control - Non-prescription contraceptive supplies and devices are not covered
- Orthopedic shoes - Orthopedic shoes are not covered, except when such a shoe is an integral part of a leg brace. The orthopedic shoe exclusion does not apply to therapeutic extra-depth shoes with inserts or custom-molded shoes for an individual with diabetes
- Prescription medications - Outpatient prescription medications are not covered (unless specifically stated otherwise in the subscriber's EOC)
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility. Full-time, private-duty nursing care in the home is not covered
- Private rooms - Private rooms in a hospital or SNF is not covered unless it is deemed to be medically necessary

- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism, is not covered (except as outlined in the Medicare Coverage Issues Manual sections 35-54)
- Surgery and related services (often referred to as orthognathic surgery or maximally and mandibular osteotomy) - These are not covered for the following reasons:
    - For the improvement of an individual's facial structure in the absence of significant malocclusion correction
    - Modified condylotomy for the treatment of temporomandibular joint (TMJ) disorders or myofascial pain dysfunction because they are considered investigational in nature
    - For correction of articulation disorders and other impairments in the production of speech
    - For correction of distortions within the sibiliant sound class or for other distortions of speech quality (for example, hypernasal or hyponasal speech)
    - Braces and any other orthodontic services
- Therapeutic shoes - Therapeutic shoes are covered for members with diabetes. In order to be covered, the member's physician managing the member's diabetic condition certifies that the therapeutic shoes are needed because the member has diabetes and is being treated under a comprehensive plan of care
- Treatment and services for disorder for TMJ disorder - Treatment and services for TMJ disorder are covered when determined to be medically necessary, except:
    - Crowns
    - Inlays
    - Onlays
    - Dental implants
    - Bridgework (to treat dental conditions related to TMJ disorder)
    - Braces and active splints for orthodontic purposes (movement of teeth)
- Unlisted services - Any services or supplies not specifically listed in the member's EOC as covered are not covered, unless coverage is required by law
- Workers' compensation - If the member requires services for which coverage is in whole or in part either payable or required to be paid under any workers' compensation or occupational disease law, Health Net provides coverage to which the member is entitled and then pursues recovery

General Coverage Limitations (Physicians only)

The general coverage limitations are as follows:

- Any services not authorized through Health Net and Medicare are not covered (except for emergency or out-of-area urgently needed renal dialysis services; refer to the Emergency Services topic)
- Cosmetic services and supplies - The following services and supplies, irrespective of the purpose for which they are performed, are not covered: hair transplant, hair analysis, hairpieces, wigs and cranial/hair prostheses, chemical face peels, abrasive procedures of the skin, liposuction of any body part, or epilation by electrolysis or other means

The following services are not covered except when required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body
- Surgery to reform or reshape skin or bone
- Surgery to excise or reduce skin, corrective or fatty tissue that is loose, wrinkled, sagging, or excessive on any part of the body

This limitation does not apply when surgery is performed to affect breast reconstruction after a mastectomy or if coverage for cosmetic surgery is specifically provided elsewhere in the member's Evidence of Coverage (EOC) or per Medicare guidelines.

- Chiropractic care - Coverage for chiropractic services is limited to treatment by means of manual manipulation of the spine to correct subluxation, unless specifically listed in the member's EOC
- Custodial or domiciliary care - Regardless of the type of facility, custodial and domiciliary care is not covered
- Dental services - Care or treatment of teeth and gingival tissues, extraction of teeth, treatment of dental abscess or granuloma other than tumors, dental examinations and spot grinding, crowns, bridge work, onlays, inlays, dental implants, braces, and any other orthodontic appliances are not covered unless specifically provided in the member's EOC
- Duplicate Health Net coverage - If the member is covered by more than one Health Net group plan, coverage is determined by applying provisions in the Coordination of Benefits topic
- Expenses before coverage begins - Services received before the member's effective date are not covered
- Expenses after termination of coverage - Services received after coverage is terminated are not covered
- Experimental or investigative procedures - All procedures generally recognized by the organized medical community and its societies and per Medicare guidelines as experimental or investigative, including services that are solely and explicitly related to these procedures (but not including medical complications relating to or arising out of such procedures), are not covered. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community. Participation in a clinical trial that meets Medicare requirements is covered for members with a diagnosis of cancer. Such members may enroll in a clinical trial program, which is administered by the Centers for Medicare and Medicaid Services (CMS) and is separate and distinct from their Health Net plans
- Hospice benefits - Any care that is offered to control or manage terminal illness or related conditions, usually designed to be provided primarily in the member's home, is considered a hospice benefit or service. Hospice services and any other services relating to the member's terminal condition, which necessitates hospice services are not provided by Health Net under this Health Net Medicare Advantage (MA) plan to Medicare entitled members. Such members may enroll in a Medicare hospice program, which is administered by CMS and is separate and distinct from this Health Net MA plan. Health Net refers the member to a Medicare participating hospice if the member wishes to elect such coverage. If the member remains enrolled in a Health Net MA plan, the member continues to receive all coverage unrelated to hospice care or the care of the member's terminal condition through the MA plan
- Military service-connected disability - Diseases and disabilities rated by the U.S. Department of Veterans Affairs (VA) as being "service-connected disabilities" entitling members to benefits from the department, if the member obtains care through the VA
- Miscellaneous hospital expenses - Personal or convenience items, such as a telephone or television in the room at a hospital or skilled nursing facility (SNF) are not covered
- Non-covered items:
    - Disposable supplies for home use, including diapers, incontinence pads, plastic gloves, comfort items (for example, pillows or adjustable beds)
    - Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, free weights
    - Over-the-counter support appliances and supplies, such as stockings and arch supports, ace bandages

    - Hearing aids - unless specifically provided in the Schedule of Benefits, EOC or approved by Health Net or the member's participating physician group (PPG)
    - Contact or corrective lenses (except an implanted lens that replaces the organic eye lens, and one pair of eyeglasses or contact lenses following cataract surgery) and eyeglasses are not covered, unless specifically provided elsewhere in the member's EOC or under Medicare guidelines
- Non-eligible institutions - Any services or supplies furnished by a non-eligible institution, which is other than a legally operated hospital or Medicare-approved SNF, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated, are not covered
- Non-prescription birth control - Non-prescription contraceptive supplies and devices are not covered
- Orthopedic shoes - Orthopedic shoes are not covered, except when such a shoe is an integral part of a leg brace. The orthopedic shoe exclusion does not apply to therapeutic extra-depth shoes with inserts or custom-molded shoes for an individual with diabetes
- Prescription medications - Outpatient prescription medications are not covered (unless specifically stated otherwise in the subscriber's EOC)
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility. Full-time, private-duty nursing care in the home are not covered
- Private rooms - Private rooms in a hospital or long term care facility is not covered unless it is deemed to be medically necessary
- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism is not covered (except as outlined in the Medicare Coverage Issues Manual sections 35-54)
- Surgery and related services (often referred to as orthognathic surgery or maximally and mandibular osteotomy) - These are not covered for the following reasons:
- For the improvement of an individual's facial structure in the absence of significant malocclusion correction
    - To reshape or enhance the size of the chin to restore facial harmony and chin projection (for example, mentoplasty, genioplasty, chin augmentation, mandibular osteotomies, ostectomies, chin implant)
    - Modified condylotomy for the treatment of temporomandibular joint (TMJ) disorders or myofascial pain dysfunction because they are considered investigational in nature
    - For correction of articulation disorders and other impairments in the production of speech
    - For correction of distortions within the sibiliant sound class or for other distortions of speech quality (for example, hypernasal or hyponasal speech)
    - Braces and any other orthodontic services
- Therapeutic shoes - Therapeutic shoes are covered for members with severe diabetes. In order to be covered, the member's physician managing the member's diabetic condition certifies that the therapeutic shoes are needed because the member has diabetes and is being treated under a comprehensive plan of care
- Treatment and services for TMJ disorder - Treatment and services for TMJ disorder are covered when determined to be medically necessary, except:
    - Crowns
    - Inlays
    - Onlays
    - Dental implants
    - Bridgework (to treat dental conditions related to TMJ disorder)
    - Braces and active splints for orthodontic purposes (movement of teeth)
- Unlisted services - Any services or supplies not specifically listed in the member's EOC as covered are not covered, unless coverage is required by law

- Workers' compensation - If the member requires services for which coverage is in whole or in part either payable or required to be paid under any workers' compensation or occupational disease law, Health Net provides coverage to which the member is entitled and then pursues recovery

Hearing

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

Diagnostic hearing and balance evaluations are covered to determine whether the member needs medical treatment. For individual and group Medicare Advantage (MA) HMO members, the evaluation can be furnished by the member's primary care physician (PCP) , or a Health Net participating ear specialist or audiologist when referred by the member's PCP. MA PPO members can self-refer for in-network or out-of-network levels of coverage.

Some individual and group MA HMO plans cover routine hearing tests by a Health Net participating audiologist when referred by the member's PCP.

Individual Plan Coverage Hearing Aids

Hearing aid coverage is included for some individual MA HMO plans. Refer to the member's Schedule of Benefits, Summary of Benefits, Evidence of Coverage (EOC) for specific information on plan coverage and exclusions.

For plans that cover hearing aids, the member must obtain the hearing aids directly through Hearing Care Solutions. Members must call Hearing Care Solutions directly to schedule an appointment. Referrals are not required.

Group Plan Coverage Hearing Aids

Hearing aid coverage is included under some group MA HMO plans as an enhanced benefit. Refer to the member's Schedule of Benefits and EOC for specific information on plan coverage and exclusions.

If and when a plan covers a hearing aid, it must be obtained through a Health Net PCP or PPG (for members affiliated with a PPG). The provider is contractually required to refer the member to a Health Net participating hearing aid provider.

If the member has a personal preference for an alternative model of hearing aid carried by the participating hearing aid provider, the member is liable for any difference in cost from the covered standard model and the preferred alternative model. A member who would like to purchase a model with special features is entitled to be informed of the additional cost before purchasing the hearing aid.

HIV Testing and Counseling

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

One screening exam every 12 months is covered for members who request HIV screening or who are at increased risk for HIV. For pregnant members, Medicare covers up to three HIV screening exams during a pregnancy. Members may access confidential HIV counseling and testing services through Health Net participating providers and through the out-of-network local health department and family planning providers. HIV testing may require prior approval.

Home Health Care

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

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

Home Health Care Services

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

The following are additional components of home health care:

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

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

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

Service Providers

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

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

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

Homebound Determination

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

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

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

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

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

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

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

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

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

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

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

Exclusions and Limitations

The following are not covered:

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

Authorization Guidelines

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

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

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

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

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

Physician Certification

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

Physician Recertification

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

Ongoing Care

Participating providers initiate home health care services as follows:

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

For more information, select any subject below:

- Skilled Nursing Services

Skilled Nursing Services

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

The following are skilled services other than skilled nursing services:

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

Skilled Nursing Observation and Evaluation

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

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

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

Information from the member's home health record must document that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the three-week period. Signs and symptoms, such as abnormal or fluctuating vital signs, weight changes, edema, symptoms of medication toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation, may justify skilled observation and assessment. When these signs and symptoms demonstrate reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the member's treatment, then services are covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the member's illness or injury where fluctuating signs and symptoms have been part of a longstanding pattern of the member's condition, which has not previously required changes to the prescribed treatment.

Hospice Care

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

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

Select any subject below:

- Hospice Care
- Prior to Election of Hospice Services

Hospice Care

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

Medicare hospice benefits are administered only through the original Medicare program. After the member has elected hospice, the member remains enrolled in the Health Net Medicare Advantage (MA).

For hospice services covered by Medicare Part A or B that are related to the terminal illness, the hospice provider bills Medicare and Medicare pays for hospice service and any Medicare Part A or B services.

For hospice services covered by Medicare Part A or B that are not related to terminal illness (except for emergency or urgently needed care), the provider bills Medicare for services and Medicare pays for the services covered by Medicare Part A and Part B.

Medications are never covered by both hospice and Health Net at the same time. Health Net covered non-hospice Part D medications are paid for by Health Net.

Health Net covered services, not covered by Medicare Part A or B that are offered as enhanced or supplemental benefits, whether they are related to terminal illness or not, are paid for by Health Net.

After the hospice election form is signed, all professional, ancillary and institutional claims for other Medicare-covered non-hospice services and services that are enhanced benefits under Health Net's MA plans must be submitted first to the Medicare administrator contractor. For more information on claims, refer to Claims Submission listed below. For additional information on cost-sharing and provider payment, refer to the table below.

The requirements for admission in the Medicare hospice program are:

- The attending physician certifies that the member is terminally ill and is expected to live six months or less
- The member chooses to receive only hospice care from a Medicare-certified hospice instead of therapeutic care under the MA plans for the terminal illness
- The member has a caregiver available 24 hours a day
- Care is provided by a Medicare-certified hospice program

Definition of Hospice Services

Hospice services are covered when the Health Net member has met hospice care requirements and the services are authorized by Health Net or a participating provider. Health Net or the participating physician group (PPG) is required to certify the member as terminally ill. The hospice and its employees must be licensed and certified by Medicare. For additional information, refer to Criteria for Hospice Appropriateness (PDF).

Covered Hospice Services

The following services are covered under hospice when related directly to the terminal illness:

- Professional services of a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy and speech therapy
- Medical and surgical supplies and durable medical equipment
- Prescribed medications
- In-home laboratory services
- Medical social service consultations
- Inpatient hospice room, board and general nursing service
- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family or other persons caring for the member, when respite care is covered
- Family counseling related to the member terminal condition
- Dietitian services
- Pastoral services
- Bereavement services
- Educational services
- Home health aide services consisting primarily of a medical or therapeutic nature and furnished to a member who is receiving appropriate nursing or therapy services

To be covered by Medicare, hospice services must be consistent with the member's plan of care as prepared by the hospice.

Inpatient hospital or skilled nursing care may be required for palliation and management of terminal illness and related conditions. Inpatient care may also be furnished to provide respite for the member's family or other persons caring for the member at home if the member's plan provides coverage for respite care. Only qualified personnel may perform hospice services. The type of service, rather than the qualification of the person who provides it, determines the coverage category of the service.

Member Election of Hospice

Medicare beneficiaries enrolled in managed care plans may elect hospice benefits.

A terminally ill member may have two 90-day election periods followed by an unlimited number of 60-day periods. The member may revoke the election at any time in writing by filing a document with the hospice; the member forfeits hospice coverage for any remaining days in that election period. Upon revoking the election of Medicare coverage of hospice care for a particular election period, the member resumes Medicare coverage of the benefits waived when hospice care was elected. Claims for services provided after hospice care has been

revoked but before the beginning of the month after the month hospice was revoked (and full capitation payments resume) must be submitted to the appropriate Medicare intermediary or carrier for payment.

A member who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive services through the MA plan. This is specific to any benefits other than those that are the hospice's responsibility. Through the Original Medicare program and subject to the standard rules of payment, CMS pays the hospice program for hospice care furnished to the member and the MA organization, providers and suppliers for other Medicare-covered services furnished to the member.

The table below summarizes the cost-sharing and provider payments for services furnished to an MA plan member who elects hospice.

Cost-Sharing and Provider Payment

Type of Service	Member Coverage Choice	Member Cost-Sharing	Payment to Providers
Hospice program	Hospice program	Original Medicare cost-sharing	Original Medicare
Non-hospice, Part A and B	MA plan or Original Medicare	MA plan cost-sharing, if member follows MA plan rules Original Medicare cost-sharing, if member does not follow MA plan rules	Original Medicare
Non-hospice, Part D	MA plan (if applicable)	MA plan cost-sharing	Health Net
Supplemental	MA plan	MA plan cost-sharing	Health Net

Hospice Consideration Request Letter

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

Services Unrelated to the Terminal Condition

Coverage under Original Medicare for conditions completely unrelated to the terminal condition for which hospice was elected remains available to the member if they are eligible for such care. The member is also eligible for enhanced benefits offered by Health Net's MA plans.

The participating provider must inform the hospice and the member that, regardless of the forms signed upon election and admission to a hospice program, the member is still required to have all non-hospice-related care directed, arranged and authorized, if required, by the member's PCP or the PPG, with the exception of Violet plan members who can select either a participating or non-participating provider, depending on the desired level of coverage.

If a member electing hospice needs prescription medications for conditions not related to hospice care, these costs are the MA organization's responsibility to the extent the medications are covered under Part D or the MA organization's plan.

Certification of Terminal Illness

The participating provider must contact the Health Net Utilization Management Department to report each instance the provider executes a Certificate of Terminal Illness for a member.

To receive payment for Medicare-covered hospice services, a hospice provider must obtain a written certification of the member's terminal illness from the member's primary care physician (PCP) or attending physician who has the most significant role in determining and delivering the member's medical care for the first 90-day period of hospice coverage. The certification must be on file in the hospice patient's record prior to the provider submitting a claim for hospice-related services. Certifications may be completed up to two weeks before the member elects hospice care. For subsequent hospice election periods, the hospice must obtain, no later than two calendar days after the first day of each election period, a written certification from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The first election period is for a 90-day period. An individual may elect to receive Medicare coverage for an unlimited number of election periods of hospice care. The periods consist of two 90-day periods followed by an unlimited number of 60-day periods.

The written certification must include:

- Statement that the member's medical prognosis is life expectancy of six months or less according to the terminal illness normal course
- Specific clinical findings and other documentation supporting the life expectancy of six months or less
- Signatures of the PCP or other participating provider who is the attending physician and a physician affiliated with the hospice

Definition of Terminal Illness

A member is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

Election of Terminal Illness

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

- Hospice program
- Member or representative's acknowledgment of full understanding of hospice care

- Hospice effective date
- Signature of member or representative
- Language explaining that the member may revoke hospice services at any time
- Member or representative's acknowledgment of full understanding that certain Medicare services are waived by the election of hospice

Face-to-Face Encounters for Continued Hospice Eligibility

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

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.

Claims Submission

Medicare's Payments to Hospice Programs

Hospice is covered by original Medicare regardless of whether a hospice patient has fee-for-service (FFS) coverage or managed care coverage. Original Medicare pays physicians, providers and suppliers for other Medicare-covered services furnished to members who have elected hospice. Other non-hospice Part D drug benefits refer to non-hospice, Part A or Part B services that are not related to the terminal illness. Once a member has been approved by the Centers for Medicare and Medicaid Services (CMS) as having elected hospice benefits, all capitation stops. However, members who have elected hospice may revoke hospice election at any time. Full monthly capitation payments resume on the first day of the month after the member has revoked hospice election.

For members who have elected hospice services, Health Net's Medicare Advantage (MA) are responsible for making available all other non-hospice Part D drug benefits and any non-hospice services that are not Medicare-covered, but that are offered as supplemental or enhanced benefits under the MA plans.

The Medicare Administrative Contractors (MACs) denies claims for any services covered under Part A or Part B furnished to a member who has elected hospice that is submitted without the GV or GW modifier. If claims are denied from the Medicare MAC due to missing GV or GW modifiers, providers should resubmit claims to the Medicare MAC with applicable. For ease of administration and timely reimbursement, participating providers should submit all claims for services rendered to a member who has elected hospice to the responsible Medicare MAC or carrier as described below. Providers must also submit claims for non-Medicare covered services, which are offered as enhanced benefits by the Health Net plan to the Medicare MAC or carrier. Refer to the member's Evidence of Coverage (EOC) for descriptions of enhanced benefits.

When a participating provider renders other Medicare-covered services unrelated to the terminal illness or services that are covered by the MA plans as enhanced benefits, the provider must use modifier GW (for services unrelated to the terminal illness). Once the participating provider receives Medicare's Medicare Summary Notice (MSN), which describes remaining, non-Medicare covered charges for services, the participating provider submits a claim with the MSN to Health Net for payment of the balance according to terms of the Provider Participation Agreement (PPA). Refer to chart below for the step-by-step process of submitting hospice-member claims.

Type of Provider	Claims for Professional Services Related to Hospice Care	Claims from Facilities for Services Related to Hospice Care	Claims for Services Not Related to Hospice Care	Claims for Non-Medicare-Covered, Enhanced Benefits Offered as Part of Health Net's Benefits
Hospital	N/A	Submit claims to MAC	Submit claims to MAC for primary processing, and then to Health Net for secondary processing	Submit claims to MAC for primary processing, and then to Health Net for secondary processing
Other Ancillary Providers	Submit claims to MAC	Submit claims to MAC	Submit claims to MAC for primary processing, and then to Health Net for secondary processing	Submit claims to MAC for primary processing, and then to Health Net for secondary processing
PPG/Physician	Submit claims to MAC	N/A	Submit claims to MAC for primary processing, and	Submit claims to MAC for primary processing, and

Type of Provider	Claims for Professional Services Related to Hospice Care	Claims from Facilities for Services Related to Hospice Care	Claims for Services Not Related to Hospice Care	Claims for Non-Medicare-Covered, Enhanced Benefits Offered as Part of Health Net's Benefits
			then to Health Net for secondary processing	then to Health Net for secondary processing
Certified Hospice Providers	N/A	Submit claims to regional home health intermediaries (RHHIs)	N/A	N/A

If a member who has elected hospice needs prescription medication for conditions not related to hospice care, these costs are the MA organization's responsibility to the extent the medications are covered under Part D or under the MA organization's plan formulary.

Federal regulations require that the RHHIs are responsible for paying for hospice services and for claims the RHHI may pay as a regular servicing MAC for managed care members who elect hospice. MAC claims for Medicare-covered services not related to the terminal illness are the responsibility of another MAC.

Revocation of Hospice Election

Members who have elected hospice may revoke hospice election at any time. When this occurs, general coverage under Medicare is reinstated for the member. Full monthly capitation payments resume on the first day of the month after the member has revoked hospice election. Claims for services provided after hospice has been revoked, but before the beginning of the month after the month hospice was revoked (and full capitation payments resume), must be submitted to the appropriate Medicare intermediary or carrier for payment.

Prior to Election of Hospice Services

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

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

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

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

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

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

Hospital and Skilled Nursing

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

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

Select any subject below:

- Claims Submissions
- Fee-for-Service Hospital and SNF Inpatient Services
- Transfer and Discharge Refusals by Hospitalized Member
- When Coverage Becomes Effective while Member is Hospitalized
- When Coverage Terminates While Member is Hospitalized

Claims Submissions

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

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

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

Fee-for-Service Hospital and SNF Inpatient Services

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

Hospital and skilled nursing facility (SNF) services are covered on all Health Net plans. Hospital services are covered for unlimited days per admission. SNF standard coverage is limited to 100 days per Centers for Medicare and Medicaid Services (CMS)-defined benefit period. Details on fee-for-service (FFS) hospital and SNF inpatient services are as follows:

- Inpatient services in an acute care hospital are covered for unlimited days, subject to scheduled copayments
- Services can be in an acute, general or specialized care hospital
- Care in a semi-private room of two or more beds is covered. Special treatment units licensed by the state, such as intensive or coronary care units, are also covered, subject to scheduled copayments
- Benefits for hospital care are limited to the hospital's most common charge for a semi-private (two-bed) room. If the member elects to have a private room, the member is responsible for any amount over the semi-private room rate, plus the plan copayment. If Health Net has authorized a private room as medically necessary, the member has no financial responsibility beyond the required copayment
- All inpatient services and supplies medically necessary and not specifically excluded for the condition necessitating confinement are covered, subject to the scheduled copayment
- Hospital-based physicians are paid for interpretive and consultative services

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

Hospital and SNF Inpatient Services

Hospital and skilled nursing facility (SNF) services are covered on by Health Net plans. Hospital services are covered for unlimited days per admission. SNF standard coverage is limited to 100 days per benefit period according to Centers for Medicare and Medicaid Services (CMS)-defined standards as described in 42 CFR, section 409.60. Details on hospital and SNF inpatient services are as follows:

- Inpatient services in an acute care hospital are covered for unlimited days, subject to scheduled copayments
- Hospitalization of Health Net members is at the discretion of the participating physician group (PPG), if the member is affiliated with a capitated PPG that has responsibility for prudent hospital use or Health Net. Services can be in an acute, general or specialized care hospital
- Prior authorization is required for Health Net Medicare Advantage (MA) PPO members accessing the in-network level of coverage for all elective inpatient admissions
- Care in a semi-private room of two or more beds is covered. Special treatment units licensed by the state, such as intensive or coronary care units, are also covered, subject to scheduled copayments
- Benefits for hospital care are limited to the hospital's most common charge for a semi-private (two-bed) room. If the member elects to have a private room, the member is responsible for any amount

over the semi-private room rate, plus the plan copayment. If the PPG or Health Net has authorized a private room as medically necessary, the member has no financial responsibility beyond the required copayment
- All inpatient services and supplies medically necessary and not specifically excluded for the condition necessitating confinement are covered, subject to the scheduled copayment

Inpatient Services in a Skilled Nursing Facility

Standard coverage for inpatient services in a SNF is limited to 100 days per benefit period (refer to the specific plan chart in the Schedule of Benefits for exceptions). To count as part of the basic 100-day SNF benefit, the member must be in a Medicare-certified facility.

The Medicare provisions governing qualification for skilled nursing benefits (for example, prior three-consecutive-day hospitalization within 30 days of SNF admission) do not apply to Health Net MA members. Although the Health Net MA plan waives the requirement of three-day hospitalization preceding admission to a SNF, the member's days in the SNF are counted towards the required 100-day maximum as long as the member is in a Medicare-certified facility.

Prior to the termination of SNF services, the valid written notice of the decision to terminate covered services is issued no later than two days before the proposed end of the services. If the member's services are expected to be fewer than two days in duration, the member is notified at the time of admission to the facility. A member who receives advance notice and agrees to the termination of SNF services earlier than 2 days, may waive the continuation of services.

Return to Home Skilled Nursing Facility

Health Net and its delegated participating physician groups (PPGs) must provide medically necessary coverage of post-hospital extended care services to members through a home skilled nursing facility (SNF) according to the following:

- The member elects to receive the covered services through the home SNF
- The home SNF either has a contract with Health Net or the PPG, or the SNF agrees to accept substantially similar payment under the same terms and conditions that apply to contracting SNFs

A home SNF is defined as:

- The SNF in which the member resided at the time of admission to the hospital preceding the receipt of post-hospital extended care services
- A SNF that is providing post-hospital extended care services through a continuing care retirement community in which the member was a resident at the time of admission to the hospital. A continuing care retirement community is an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period
- The SNF in which the spouse of the enrollee is residing at the time of discharge from the hospital. The term spouse includes individuals of the same sex who are lawfully married under the laws of the state, as well as individuals of the same sex who are domiciled in a state that recognizes their relationship as a marriage

The post-hospital extended care scope of services, cost-sharing, and access to coverage provided by the home SNF is to be no less favorable to the member than post-hospital extended care services coverage that

would be provided to a member by a SNF that would be otherwise covered under the plan. For MA PPO members, the in-network cost-sharing applies.

Health Net does not require a prior qualifying hospital stay before a medically necessary admission to a SNF. In applying the above definition of home SNF, refer to wherever the member resided immediately before admission for extended care services.

Transfer and Discharge Refusals by Hospitalized Member

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

Participating Facility

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

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

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

Transfer of Hospitalized Member to Participating Facility

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

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

When Coverage Becomes Effective while Member is Hospitalized

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

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

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

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

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

When Coverage Terminates While Member is Hospitalized

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

If Health Net coverage begins while the member is hospitalized, the prior carrier must continue coverage until one of the following occurs:

- Health plan benefits are exhausted before the member is discharged.
- The member is discharged from the hospital. If a member is confined to a hospital and is transferred to another hospital with no more than a 24-hour lapse in care, the confinement is a continuous hospital stay.

The prior carrier is responsible for covering the stay until the member is discharged from the hospital or moved to a non-acute, inpatient hospital level of care (for example, a skilled nursing facility (SNF) within the same hospital).

Health Net and the participating physician group (PPG) are liable after the member is discharged or transferred to a lower level of care.

Immunizations

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

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

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

For members covered by Medicare Part B or the medical benefit, covered immunizations include influenza, pneumococcal and hepatitis B, and other vaccines where the member is at risk.

All other immunizations are covered under Medicare Part D. If the member does not have Part D coverage, then other immunizations are not covered.

Specified immunizations are covered in all the following instances:

- Influenza and pneumococcal vaccines: In accordance with the federal regulations governing Medicare, members may self-refer for influenza and pneumococcal vaccines with no copayments. Participating providers should address the following items to help ensure compliance with this requirement:
  - Allow self-referral within the Health Net Medicare Advantage (MA) network
  - Participating providers that are unable to provide these vaccines should provide the member with a list of affiliated clinics
- Hepatitis B vaccines are covered for high and intermediate-risk groups only. If the condition does not fall into one of the categories listed below, the vaccine is not covered. No copayment applies if this is the only service provided:
  - High-risk group:
    - End-stage renal disease (ESRD) members
    - Hemophiliacs receiving Factor VIII or IX concentrates
    - Mentally handicapped, institutionalized residents
    - Persons living in the same household as hepatitis B carriers
    - Homosexual men
    - Illicit drug users
  - Intermediate-risk group:
    - Staff in institutions for the mentally handicapped
    - Health care staff who have contact with blood or blood-derived body fluids

Immunizations required for foreign travel or occupational-related requirements are not covered.

Zostavax

Health Net considers the herpes zoster vaccine (Zostavax®) medically necessary for the prevention of herpes zoster (shingles) in individuals ages 50 and older, in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP).

The Centers for Medicare & Medicaid Services (CMS) considers Zostavax to be a Part D medication.

Part D Billing Options

Zostavax is administered in the provider's office. The following three procurement and billing options are currently available to providers.

Option One - Health Net's Preferred Option

Participating providers may request Zostavax by contacting Pharmacy Services. Health Net coordinates the delivery of the vaccine to the provider by Health Net's approved specialty pharmacy. The specialty pharmacy then charges Health Net and bills the member for their copayment or coinsurance, if applicable.

Option Two

With a prescription from the member's prescriber, the Health Net member may obtain Zostavax directly from a Health Net participating pharmacy, paying the applicable copayment or coinsurance. The member may take the vaccine back to their prescriber office for administration. The member must be informed that it is essential for the vaccine to remain frozen.

Option Three

The prescriber may obtain and administer Zostavax to the member and charge the member for the cost of the vaccine. The member may then submit a claim on a Health Net Medicare Prescription Claim form to Health Net for reimbursement for the cost of the medication, less the member's copayment or coinsurance (if applicable).

Initial Health Appointment

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

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

Select any subject below:

- Requirements

Requirements

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

Health Net and participating providers must make best-effort attempts to conduct initial assessments of each member's health care needs, including following up on unsuccessful attempts to contact a member, within 90 days of the effective date of enrollment.

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:

- Home Infusion
- Human Growth Hormone and Antihemophilic Factor
- Prior Authorization
- Self-Injectable Medications
- Therapeutic Injections and Other Injectable Substances

Home Infusion

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

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

- Total parenteral nutrition (TPN)
- Intravenous antibiotic and antiviral therapies
- Aerosolized therapy
- Pain management
- Chelation therapy
- Inotropic therapy
- IVIG/IGIV immunoglobins
- Hydration therapy
- Steroid therapy
- Remicade
- Chemotherapy

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

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

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

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

Human Growth Hormone and Antihemophilic Factor

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

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

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

Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG)

There are three options for submitting a prior authorization form:

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

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

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

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

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

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

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

Self-Injectable Medications

Provider Type: Physicians | Participating Physician Groups (PPG)

Self-injectable medications are covered under the prescription drug benefit. Refer to the Medicare Part D Formulary to verify coverage.

Health Net follows Medicare coverage guidelines for self-injectable medications. Examples of self-injectable medications that are covered under Medicare Part B include blood clotting factors, medications used in immunosuppressive therapy, erythropoietin for dialysis members, and osteoporosis medications for certain homebound members. To verify coverage for self-injectable medications, contact Pharmacy Services. Refer to the Medicare Part D Formulary for more information about self-injectable medications.

Therapeutic Injections and Other Injectable Substances

Provider Type: Physicians | Participating Physician Groups (PPG)

Therapeutic injections and other injectables are covered, subject to scheduled copayments, if applicable when their use is indicated by standard medical practices. These injections are usually administered in the office or professional outpatient facility.

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:

- Start Smart for Your Baby Care Management
- Pregnancy Termination

Start Smart for Your Baby Care

Provider Type: Physicians | Participating Physician Groups (PPG)

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

resources, our program's trimester-based assessment approach ensures continuous care and guidance for existing and developing conditions.

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

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

PROFESSIONAL CARE FOR PREGNANCY

Hospital and professional pregnancy services are covered, including:

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

must provide written disclosure of all the above to the member (Note: Newborn care is not covered under Medicare Advantage plans).
- Continuation of obstetrical services for terminated members. If a female member is terminated from a Health Net group agreement, coverage for obstetrical services is provided when there is a continuation of coverage through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the conversion plan.

GENETIC TESTING AND COUNSELING

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

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

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

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

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

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

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

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

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

Pregnancy Termination

Provider Type: Participating Physician Groups (PPG)

In accordance with Medicare guidelines, abortions are not covered, except under the following circumstances:

- The pregnancy is the result of an act of rape or incest

- A woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a provider, place the woman in danger of death unless an abortion is performed

Medical Social Services

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

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

Select any subject below:

- Coverage Explanation
- PPG Responsibility

PPG Responsibility

Provider Type: Participating Physician Groups (PPG) | Hospitals

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

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

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

Coverage Explanation

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

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

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:

- Certified Nurse Midwives

Certified Nurse Midwives

Provider Type: Participating Physician Groups (PPG)

Services provided by a certified nurse midwife (CNM) are covered and include those furnished during the maternity cycle - a period that includes pregnancy, labor, birth, and the immediate postpartum period, not to exceed 67 weeks.

There is no restriction on the place of service; therefore, CNM services are covered if provided in the CNM's office, in the member's home, or in a hospital or other facility, such as a clinic or birthing center owned and operated by the CNM.

Services provided outside the maternity cycle are also covered.

Obesity

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

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

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

Coverage

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

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

Resources

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

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

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

The following information does not apply to Medi-Cal

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

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

For more information on, select any subject below:

- Bariatric Surgery Services

Bariatric Surgery Services

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

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

Outpatient Services

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

This section contains general member benefit information on outpatient services.

Select any subject below:

- Coverage Explanation
- Alternative Birth Centers
- Ambulatory Surgical Centers
- Ambulatory Surgical Centers Payments
- Office Visit
- Outpatient Hospital Services and Supplies
- Urgent Care Centers

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Alternative Birth Centers

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

Ambulatory Surgical Centers

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Ambulatory Surgical Centers Payments

Provider Type: Participating Physician Groups (PPG)

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

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

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

Office Visit

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Well-Woman Self Referrals

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

Coverage Explanation

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

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

Outpatient Hospital Services and Supplies

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Urgent Care Centers

Provider Type: Participating Physician Groups (PPG)

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

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

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

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

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

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

Physicians Visit

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Homebound Members

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

Podiatry

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net Medicare Advantage (MA) HMO plans cover Medicare-covered podiatry services if determined to be medically necessary by the member's participating physician group (PPG) or Health Net.

Routine podiatry care must be coordinated through the primary care physician (PCP), unless otherwise designated by the PPG, and is limited to one visit per calendar month. This provides coverage for members who cannot adequately give themselves routine foot care. An example of covered routine foot care is toenail trimming for a member with an arthritic condition of the hands who is not able to perform the task. Routine foot care is covered, as deemed necessary by the PCP. Additionally, although the routine foot care benefit is limited to one visit per calendar month, the PCP should determine the frequency of visits. In some instances, the member may need routine podiatry care less frequently.

Routine podiatry services are the following:

- Cutting or removal of corns or calluses
- Trimming, cutting, clipping, or debridement of nails
- Other hygienic preventive maintenance care in the realm of self-care for both ambulatory and bed confined members

If the PCP does not perform the routine podiatry services, the PPG must refer the member to a licensed practitioner that does. Members are required to obtain a referral from the PCP for up to six visits or as specified by the PPG.

In addition, routine podiatry services are covered for Health Net MA members who are institutionalized in a nursing home or convalescent home, regardless of their medical diagnosis. Such routine podiatry care must be ordered by the PCP and is limited to one visit per calendar month. These visits are subject to scheduled copayments.

Post Stabilization

Provider Type: Participating Physician Groups (PPG)

Post-stabilization care (also referred to as maintenance care after an emergency medical condition) consists of services related to emergency medical conditions, that are provided after a member is and remains stabilized or, in certain cases, to improve or resolve the member's condition, from the time that the treating hospital requests authorization from Health Net until one of the following occurs:

- Member is discharged
- Primary care physician (PCP) arrives and assumes responsibility for the member's care
- Treating physician and Health Net agree to another arrangement

Coverage Explanation

The physician treating the member must decide when the member may be considered stabilized for transfer of discharge. For transfers from one inpatient setting to another inpatient setting, a member or the person authorized to act on their behalf who disregards the decision and believes the member cannot safely be transferred may request that Health Net or PPG pay for continued out-of-network services. If the request is denied, appeal rights must be provided to the member.

PPG Responsibility

When a facility contacts a participating physician group (PPG) with a request for post-stabilization services for a Health Net member, the PPG must immediately contact (or refer the call to) the Health Net Medical Management Department . Health Net then works closely with the attending physician or facility and the member's primary care physician (PCP) or PPG on continuity of care.

All PPGs are required to provide 24-hour on-call access to a physician to authorize and coordinate any necessary post-stabilization services.

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
- Intensive Behavioral Therapy for Obesity
- PPG Responsibility

Overview

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

Preventive services are diagnostic preventive procedures. Copayments are not required most Medicare Advantage (MA) members. Female members may self-refer within their participating physician group (PPG) for routine women's health services. Coverage of diagnostic preventive procedures is based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Medicare guidelines.

When a Health Net member self-refers for routine women's health services, the provider should indicate "self-referral" in box 17 of the CMS-1500 form.

Coverage Explanation

In accordance with Medicare coverage guidelines, the following preventive care services are covered through Medicare Advantage (MA) and Medicare Supplement plans:

1. Welcome to Medicare physical exam (one time only) within 12 months of the member's first coverage under Part B. Exam includes measurement of height, weight and blood pressure; an

electrocardiogram; education, counseling and referral with respect to covered screening and preventive services.
2. Personalized preventive plan services; Medicare-covered annual wellness visit - available within the first 12 months of Medicare B coverage or once a year beginning 12 months after the Welcome to Medicare physical exam.
3. Cardiovascular disease screening blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease), including tests for cholesterol and other lipid or triglyceride levels. There is no copayment for screening blood tests.
4. Diabetes screening tests for persons at risk of diabetes, including a fasting plasma glucose test. Individuals are considered at risk for diabetes if they have one of the following risk factors:
    1. Hypertension, dyslipidemia, obesity (body mass index (BMI) greater than or equal to 30kg/m2).
    2. Previous identification of an elevated impaired fasting glucose or glucose intolerance.
    3. Individuals who have one or more of the following risk factors:
        1. Overweight (BMI greater than 25, but less than 30kg/m2).
        2. Family history of diabetes, age 65 or older, a history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds.
    4. Annual glaucoma screening for Medicare beneficiaries at high risk, who have a family history of the disease or who have diabetes.
5. A baseline mammogram for female Medicare beneficiaries ages 35 to 39 and an annual mammogram for female Medicare beneficiaries ages 40 and over.
6. Medical nutrition therapy by registered dietitians or other qualified nutrition professionals for Medicare beneficiaries with diabetes, chronic renal disease and post-transplant members. These benefits include:
    1. An initial assessment of nutrition and lifestyle assessment.
    2. Nutrition counseling.
    3. Information regarding managing lifestyle factors that affect diet.
    4. Follow-up visits to monitor progress in managing a diet.
7. Abdominal aortic aneurysm screening ultrasound covered one time for Medicare beneficiaries at risk through referral received from Welcome to Medicare physical exam.
8. Bone mass measurements every two years for qualified individuals considered to be at risk for osteoporosis. A qualified individual is a Medicare beneficiary who meets the medical indications for one of the following categories:
    1. An estrogen-deficient woman.
    2. An individual with vertebral abnormalities.
    3. An individual with known primary hyperparathyroidism.
    4. Some individuals receiving steroid therapy.
    5. Individuals receiving FDA-approved osteoporosis medication therapy.
    6. Procedures to identify bone mass, detect bone loss or determine bone quality, including a physician's interpretation of the results.
9. Prostate cancer screening exams for male Medicare beneficiaries ages 50 and over. These exams include a digital rectal exam and a prostate-specific antigen (PSA) test (annually).
10. Influenza and pneumococcal vaccines - Medicare members may self-refer for influenza and pneumococcal vaccines with no copayments. Providers should address the following items to help ensure compliance with this regulation:
    1. Providers should allow self-referral within the PPG.
    2. Providers unable to provide these vaccines should provide the member with a list of affiliated clinics.
11. Hepatitis B vaccine (for Medicare beneficiaries at medium to high risk for hepatitis).

12. Diabetes self-management - Provides coverage for diabetes outpatient self-management training to include services furnished in non-hospital-based programs (already covered in hospital-based programs). Physicians may provide services to others approved by the secretary of Health and Human Services (HHS) if they also provide other services paid by Medicare and meet quality standards established by the secretary. A physician managing the member's condition must certify that the services are needed under comprehensive plan care. This includes coverage for blood glucose monitors and testing strips for all diabetics (already covered for insulin-dependent diabetics).
13. Pap test and pelvic exam every two years with no copayment or deductible for women who are at low risk for cervical cancer.
14. For female Medicare beneficiaries at high risk for uterine or vaginal cancers, an annual Pap test and pelvic exam with no copayment or deductible. Barium enema for members not at high risk every four years for members ages 50 and over.
15. One annual take-home fecal-occult blood test for members ages 50 and older.
16. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse.
17. Screening for depression in adults in primary care setting.
18. Screening for sexually transmitted infections (STIs).
19. High-intensity behavioral counseling to prevent STIs.
20. Screening for obesity and counseling for eligible beneficiaries by primary care providers.
21. Multi-target stool DNA test is covered with an at-home test once every three years for people who meet all of following conditions:
    1. Between ages 50- 85.
    2. Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.
    3. At average risk for developing colorectal cancer, meaning:
        1. Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
        2. Have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.
22. Screening flexible sigmoidoscopy every four years for Medicare beneficiaries ages 50 and older not at high risk for colorectal cancer (unless a screening colonoscopy has been performed and then Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months).
23. Screening colonoscopy including anesthesia furnished in conjunction with screening colonoscopy for Medicare beneficiaries not at high risk for colorectal cancer every 10 years and every two years for members at high risk (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after 47 months).
24. Screening barium enema every four years for those not at high risk or two years for those at high risk (as an alternative to covered screening flexible sigmoidoscopy).

No office visit or facility copayment is required when only preventive services are provided to members of Medicare Advantage (MA) HMO plans and members using the in-network level of coverage for MA PPO plans.

Intensive Behavioral Therapy for Obesity

Provider Type: Physicians | Participating Physician Groups (PPG)

As required by the Centers for Medicare & Medicaid Services (CMS), Health Net covers screenings for obesity and counseling by primary care physicians (PCPs) without cost-share for eligible members.

Assessment

Medicare members with obesity, defined as a body mass index (BMI) equal to or greater than 30 kg/m^2 (weight in kilograms divided by the square of height in meters), who are competent and alert at the time counseling is provided and whose counseling is furnished by a qualified PCP in a primary care setting, are eligible for:

1. One face-to-face visit every week for the first month.
2. One face-to-face visit every other week for months two to six.
3. One face-to-face visit every month for months 7-12, if the beneficiary meets the 3 kg (6.6 lb.) weight-loss requirement during the first six months.

Medicare coinsurance and Part B deductible are waived for this service.

Reassessment

At the six-month visit, the provider should reassess the member and determine the amount of weight loss. To be eligible for additional face-to-face visits occurring once a month for months 7-12, members must have lost at least 3 kgs (6.6 lbs.) over the course of the first six months of intensive therapy. Providers must document this determination in members' medical records consistent with usual practice.

If the member has not met the 3 kg weight-loss requirement during the first six months, they are not eligible for continuing monthly visits. However, after an additional six months, the member is eligible for a reassessment of their BMI and readiness to change.

Intensive behavioral therapy (IBT) Components

IBT for obesity consists of the following:

1. Screening for obesity in adults using the measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m2).
2. Dietary (nutritional) assessment.
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity diet and exercise interventions.

Intensive behavioral intervention for obesity should be consistent with the following:

1. Assess - Assess behavioral health risk(s) and factors affecting choice of behavior change methods or goals.
2. Advise - Give clear, specific and personalized behavior change advice, including information about personal health harms and benefits.
3. Agree - Collaboratively select appropriate treatment goals and methods based on the member's interest in and willingness to change the behavior.

4. Assist - Using behavior change techniques (such as self-help or counseling), aid the member in achieving agreed-upon goals by acquiring the skills, confidence and social or environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. Arrange - Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/ support and to adjust the treatment plan as needed, including offering referral to more intensive or specialized treatment, as necessary.

Billing Requirements

Providers must submit claims, with the following HCPCS or ICD-10, and place-of-service codes. If the claim does not include this information, it is denied.

Types of Codes	Codes and Descriptions
Diagnostic	HCPCS code - G0447 face-to-face behavioral counseling for obesity HCPCS code - G0473 face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
ICD-10	Z68.30 - Z68.39, Z68.41 - Z68.45
Specialty	01 - general practice 08 - family practice 11 - internal medicine 16 - obstetrics/gynecology 37 - pediatric medicine 38 - geriatric medicine 50 - nurse practitioner 89 - certified clinical nurse specialist 97 - physician assistant
Place of Service	11 - physician's office 22 - outpatient hospital 49 - independent clinic 71 - state or local public health clinic

Frequency Limitation

Medicare pays for G0447 with an ICD-10 code of Z68.30 - Z68.39 or Z68.41 - Z68.45, no more than 22 times in a 12-month period. Line items on claims beyond the 22nd time are denied using the following codes:

1. CARC 119 - Benefit maximum for this time period or occurrence has been reached.
2. RARC N362 - The number of days or units of service exceeds our acceptable maximum.
3. Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed advance beneficiary notice of non-coverage (ABN) is on file).

4. Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When applying this frequency limitation, a claim for the professional service and a claim for a facility fee are allowed.

PPG Responsibility

Provider Type: Participating Physician Groups (PPG)

Participating physician groups (PPGs) must address the following items to help ensure compliance with federal regulations:

1. PPGs must allow female members to self-refer to gynecologist providers within the member's PPG.
2. PPGs may not collect copayments from Health Net members for annual mammograms.

- If the PPG is not affiliated with a mammography center, a list of certified centers is available from Cancer Information Services or the Food and Drug Administration's (FDA's) website at www.fda.gov.
- Capitated PPGs are liable for fee-for-service (FFS) claims if the member obtains services from an out-of-network mammography center.

The Centers for Medicare & Medicaid Services (CMS) and Health Net review each participating physician group's (PPG's) list of mammography centers to determine sufficient member access within the PPG. If members obtain these services from unaffiliated or noncontracting facilities due to insufficient member access, Health Net has the authority to bill the PPG for the charges.

Prosthesis

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

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

Select any subject below:

- Overview

Overview

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

Prosthetics needs may be referred to any Health Net participating provider. Health Net has a supplier contract with Linkia, LLC, which is Health Net's preferred provider for orthotics and prostheses. Health Net encourages the use of Linkia for these services whenever possible. For those prosthetics supplies not available through Linkia, they may be obtained by any other Health Net contracting provider.

Coverage Explanation

Prostheses and supplies include:

- artificial limbs
- artificial eyes
- artificial larynx devices after a laryngectomy
- breast prostheses
- colostomy and ostomy supplies
- contact lenses after cataract surgery
- C.V., midline and peripheral catheters
- enteral supplies
- phenylketonuria (PKU) formulas and food products
- tracheostomy supplies
- ventilator supplies

Breast Prostheses

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

Post-Cataract Benefits

Health Net covers the surgically implanted conventional intraocular lens (IOL) and a pair of glasses to replace the organic eye lens following the surgical extraction of a cataract. Post-cataract surgery eyeglasses or post-cataract surgery contact lenses are covered under the prosthetic benefit for members who did not receive an implanted lens after lens extraction.

Preferred Provider

Linkia, LLC provides both prostheses and the supplies required to maintain prostheses, which are also covered. Contact Linkia to obtain the telephone number of the nearest location. Covered prostheses supplies that are not provided by Linkia may be obtained through any Health Net contracting provider.

Rehabilitation Therapy

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

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

Select any subject below:

- Overview
- Physical, Occupational or Speech Therapy Services Concurrent Review Forms

Overview

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

Rehabilitation therapy (physical, speech, occupational, chiropractic, and respiratory) is covered after an acute illness or injury or an acute exacerbation of either. Coverage for continuation of rehabilitation is based on continuous functional improvement in response to the treatment plan. Rehabilitation services are deemed to be no longer medically necessary when there is objective evidence that the member has not demonstrated continuous functional improvement in response to the treatment plan.

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

Coverage Explanation

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

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

Institutional and professional services provided for inpatient and outpatient rehabilitation are covered. Refer to the Health Net Provider Participation Agreement (PPA) for financial responsibility information.

Cardiac Rehabilitation

The program is considered medically necessary and reasonable only for a member with a clear medical need and who is referred by their attending physician. The member must have one of the following:

- A documented diagnosis of myocardial infarction within the preceding 12 months
- Coronary bypass surgery
- Stable angina pectoris

The Health Net Medicare Advantage (MA) and Cal MediConnect plans cover cardiac rehabilitation when services are provided in an outpatient department of a hospital or a physician-directed clinic.

Services that may be covered include diagnostic stress testing, electrocardiogram (ECG) rhythm strips, therapeutic psychotherapy and psychological diagnostic testing, physical and occupational therapy, and member education services.

The duration of the cardiac rehabilitation program may be considered reasonable and necessary for up to 36 sessions (usually three sessions a week in a single 12-week period). Services may be covered only when supported by the attending physician's documentation.

Cardiac rehabilitation in excess of 12 weeks is covered only on a case-by-case basis.

Home Health Services

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

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

Neuromuscular Rehabilitation Therapy

Neuromuscular rehabilitation programs are directed by a physician experienced or trained in neuromuscular rehabilitation, and supported by rehabilitative nursing. The ancillary services of physical therapy (PT) and occupational therapy (OT) are necessary for all of the programs cited. Psychological and social services should be provided depending on the member's need. In addition to these basic services, the stroke rehabilitation program may require PT and OT, and the pulmonary rehabilitation program may require inhalation therapy.

For Health Net Medicare Advantage (MA) and Cal MediConnect plans, the following Medicare guidelines are provided for assistance in authorizing neuromuscular rehabilitation services:

- The services must be directly and specifically related to an active written treatment regimen designed by the physician or by a qualified physical or occupational therapist
- The services must be of such a level of complexity and sophistication, or the condition of the member must be such that the judgment, knowledge and skills of a qualified physical or occupational therapist are required

- The services must be performed by or under the supervision of a qualified physical or occupational therapist
- The services must be provided with the expectation, based on the primary care physician's (PCP's) or attending physician assessment of the member's restorative potential after any needed consultation with the therapist, that the member improves significantly in a reasonable, and generally predictable, period of time, or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state
- The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition
- The services must be necessary for treatment of the member's condition

Services related to activities for the general good and welfare of members, for example, general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute PT or OT services for Medicare purposes and, consequently, are not covered.

Optional Rehabilitation Therapy Coverage

While coverage for standard rehabilitation therapy is based on continuous functional improvement in response to the treatment plan that is demonstrated by objective evidence, the optional coverage requires only that the services improve the condition or relieve symptoms and maintain or increase the member's level of functional independence.

After a maximum of one year of optional rehabilitative therapy, coverage returns to the standard benefit. Thereafter, additional therapy is covered only if there is continuous functional improvement in response to the treatment plan, as demonstrated by objective evidence.

Physical, Occupational or Speech Therapy Services Concurrent Review Forms

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

Physical, Occupational or Speech Therapy Services Concurrent Review Forms

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

Providers must use the Urgent Request for Continuing Occupational, Physical or Speech Therapy (PDF) concurrent review form for HMO/POS, PPO, EPO, and Medicare Advantage members continuing physical,

occupational or speech therapy and home health services. Completed forms must be faxed to the Health Net Prior Authorization Department.

Respite Care

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

Aside from custom plans requested by specific Medicare Advantage (MA) employer groups, respite care is not a standard benefit other than what is provided through the hospice benefit covered by Medicare. Respite care is short-term care provided to the member only when necessary to relieve family members or others caring for the member at home. Respite care may be provided in the member's home, in a nursing facility or in an assisted living facility. This is covered only when provided occasionally and reimbursement is not made for more than five consecutive days within a two-month period. One day is counted for any day in which one visit occurs. There must be a minimum of one day without respite care between successive two-month periods. Respite care coverage does not have a lifetime maximum.

Requirements

When a MA employer group plan provides respite care, requirements for respite care coverage are:

- Prior authorization by the Health Net Medical Management Department
- Member must have been receiving care for at least three activities of daily living (ADLs) for a period of four consecutive months. ADLs include bathing, dressing, eating, continence, mobility, going to the toilet, and transferring

Coverage Explanation

The respite care benefit, when provided by an MA employer group plan, is as follows:

- In-home care coverage is limited to a maximum of 40 visits per calendar year, with a 15-visit maximum within a two-month period. For in-home care, the member may have up to three visits per day (up to eight hours each visit)
- Facility-based care coverage is limited to a maximum of 30 days per calendar year. Facility-based care may be in either a residential care facility for the elderly or a skilled nursing facility (SNF)

Routine Physical Exam

Provider Type: Physicians | Participating Physician Groups (PPG)

Annual routine physical examinations differ from periodic health examinations, which are also covered under the Health Net Medicare Advantage (MA) plans. An annual routine physical exam is one that is not physician-directed and is done for the purpose of checking a member's general health in the absence of symptoms. Examples include exams taken to obtain or maintain employment, licenses or insurance, or exams administered at the request of a third party, such as a school, camp or sports-affiliated organization.

One annual routine physical exam requested by the member without medical condition indications is covered along with any related X-ray and laboratory procedures ordered or approved by the physician. The exam is subject to scheduled copayments.

Routine physical exam coverage allows the member to request services not otherwise medically indicated. Refer to the specific plan in the Schedule of Benefits and Summary of Benefits for routine physical examination coverage frequency based on the member's age.

Annual Self-Referred Mammograms

In addition to annual routine physical examinations, self-referred mammograms are covered annually for female Health Net Medicare Advantage (MA) plan members as follows:

- One baseline exam between ages 35 and 39
- One screening every 12 months for women ages 40 and older

This coverage does not require prior authorization or a referral from the member's participating physician group (PPG) or primary care physician (PCP). To use this coverage, the member can go to a mammography screening center affiliated with her Health Net MA PPG or, if none is affiliated with the Health Net MA PPG, then the member must go to a certified mammography screening center. The member can contact her Health Net PPG, the Health Net Medicare Programs Member Services Department for information on claims processing and to obtain a listing of certified screening mammography centers.

Second Opinion by a Physician

Provider Type: Physicians | Participating Physician Groups (PPG)

Second opinion consultations related to member's medical need for surgery or non-surgical diagnostic or therapeutic procedures are a covered benefit. Second opinion consultations include a history, an examination and a medical decision of some complexity. Whether a second opinion request is in-network or out-of-network, an organization determination (applicable to Medicare Advantage only) must be requested. Additionally, office visits, consultations with participating physicians, or referrals to physicians or qualified professional providers necessary for obtaining a second opinion are covered and subject to scheduled copayments if applicable.

Prior authorization may be required for surgery or for a major non-surgical diagnostic or therapeutic procedure, except in an emergency. A member may contact their primary care physician (PCP) or Health Net Member Services to request authorization for a second opinion.

Additional Second Opinion

Additional second opinions (third opinions) are covered if the recommendation of the first and second opinion differ regarding the need for surgery or other major procedure. Additional opinions are covered even though the surgery or other procedures, if performed is determined non-covered. The surgery or other procedure request must be referred back to Health Net in order to be covered.

Support for Disabled Members

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

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

Select any subject below:

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

Americans with Disabilities Act of 1990

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

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

Auxiliary Aids and Services

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

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

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

Effective Communication

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

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

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

Financial Responsibility

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

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

Undue Burden

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

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

Surgery, Surgical Supplies, and Anesthesia

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

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

Select any subject below:

- Coverage Explanation
- Surgical Dressings and Exclusions and Limitations

Coverage Explanation

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

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

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

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

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

Surgical Dressings and Exclusions and Limitations

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

Surgical dressings are covered in accordance with Medicare Advantage (MA) guidelines and are limited to primary and secondary dressings medically necessary for treatment of a wound caused by, or treated by, a surgical procedure that has been performed by a physician or other health care professional. In addition, surgical dressings required after debridement of a wound are also covered, irrespective of the type of debridement, as long as the debridement was necessary and was performed by a health care professional acting within scope of licensure.

- Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin
- Secondary dressing materials are items needed to secure primary dressings, such as adhesive tape, roll gauze, bandages, and disposable compression material

TMJ

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

Temporomandibular joint (also known as TMD or TMJ) disorder commonly causes headaches, tenderness of the jaw muscles, tinnitus, or facial pain. These symptoms often occur when chewing muscles and jaw joints do not align correctly. When medically necessary and prior authorized, treatment of TMJ is covered.

Covered Services

Coverage of TMJ is limited to the following:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw when such procedures are medically necessary.
- Custom-made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD or TMJ disorders are covered if medically necessary.

Health Net of California Inc. covers orthognathic surgery for specific conditions. Refer to the National Medical Policy on Orthognathic Surgery on the Health Net provider website for additional information.

Exclusions and Limitations

Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants, or other dental appliances to treat dental conditions or dental conditions related to TMD or TMJ disorders are not covered.

For more information, select any subject below:

- Payment

Payment

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

The participating provider refers the member to their participating dentist or oral surgeon for medically necessary custom-made temporomandibular joint (TMJ) appliances (for example, occlusal splints) or medically necessary surgeries.

When items or services are covered under the member's benefit plan, claims responsibility for TMJ orthotics and services, including surgical services, are determined according to the Provider Participation Agreement (PPA) and the Division of Financial Responsibility (DOFR).

Transgender Services

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

The U.S Department of Health and Human Services (HHS) invalidated Medicare's National Coverage Determination (NCD) Manual, Section 140.3, Transsexual Surgery (effective May 30, 2014). Accordingly, its provisions are no longer a basis for denying claims for Cal Medi-Connect (Medicare Advantage based) coverage of transgender services.

Health Net is required to consider whether claims for CalMedi-Connect transgender services are reasonable and necessary as defined in the Social Security Act, Section 1862(a)(1)(A). In the absence of a documented NCD or Local Coverage Determination (LCD), Health Net applies evidence-based clinical criteria in determining medical necessity of requested services. Refer to Health Net's Gender Reassignment Surgery medical policy for clinical criteria located on the Health Net provider portal under Working with Health Net > Clinical > Medical Policies.

Transgender services refer to the treatment of GID, which may include the following:

- consultation with transgender service providers
- transgender services work-up and preparation
- psychotherapy
- continuous hormonal therapy
- laboratory testing to monitor hormone therapy
- gender reassignment surgery that is not cosmetic in nature

Medically Necessary/Reconstructive Surgery

No categorical exclusions or limitations apply to coverage for the treatment of GID. Each of the following procedures, when used specifically to improve the appearance of an individual undergoing gender reassignment surgery or actively participating in a documented gender reassignment surgery treatment plan, must be evaluated to determine if it is medically necessary reconstructive surgery to create a normal appearance for the gender with which the member identifies. Prior to making a clinical determination of coverage, it may be necessary to consult with a qualified and licensed mental health professional and the treating surgeon.

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Electrolysis

- Facial bone reduction
- Facial feminization
- Hair removal
- Hair transplantation
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Subcutaneous mastectomy
- Voice modification surgery

Cosmetic procedures are excluded from coverage. Coverage is subject to prior authorization based on medical necessity.

This section clarifies how Health Net administers benefits in accordance with the World Professional Association for Transgender Health (WPATH), Standards of Care (SOC), Version 7. Provided a patient has been properly diagnosed with gender dysphoria or GID by a mental health professional or other provider type with appropriate training in behavioral health and competencies to conduct an assessment of gender dysphoria or GID, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy, certain options for social support and changes in gender expression are considered to help alleviate gender dysphoria or GID.

For example, with respect to hair removal through electrolysis, laser treatment, or waxing, the WPATH "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.

Providers Participating through PPGs

Providers participating through PPGs must contact their PPGs' prior authorization process and use the PPG's 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
- Health Net Transplant Performance Centers
- Responsibility for Inpatient Concurrent Review and Transfer for Transplant Evaluation

Coverage Explanation

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

Prior Authorization

Health Net covers the cost of medically necessary, non-experimental and non-investigative organ and stem cell transplants at Medicare-approved, Health Net Transplant Performance Centers (Centers). Service requests are evaluated on a case-by-case basis and must be prior authorized through Health Net or the delegated participating provider group (PPG).

PPG Procedures

Delegated PPGs use the following procedure for reviewing requests for delegated transplant services:

1. The treating physician or transplant center (requestor) submits a request for transplant services to the delegated PPG Utilization Review Committee.
2. The PPG Utilization Review Committee reviews and informs the requestor of its determination.
3. If Health Net receives a request directly from a treating physician or transplant center for a delegated transplant service, the requestor is referred to the delegated PPG.

The following applies to all non-delegated PPGs

For non-delegated PPG members, all major organ and bone marrow transplants (both allogenic stem cell and autologous stem cell) requests must be submitted by the transplant service provider directly to the Centene Centralized Transplant Unit (CTU) for review. Requests received from the primary care physician (PCP), specialist or PPG will be returned, and the requestor will be informed to have the transplant center submit the request.

A PCP, specialist or non-delegated PPG who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Medicare-approved, Health Net Transplant Performance Center for transplant evaluation.

The Center must submit a prior authorization request for the evaluation to the CTU through the provider portal, or via fax directly to the CTU.

On receipt of a request for a transplant 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 for transplant by the Center, the Center must submit a prior authorization request for listing to the CTU through the provider portal or via fax directly to the CTU.

On receipt of a request for a listing, 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.

If the request meets medical necessity, but the requesting transplant center is not a Medicare-approved, Health Net Transplant Performance Center, the member may be redirected to a Medicare-approved, Health Net Transplant Performance Center.

CAR-T cell therapy, corneal transplant, tissue transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy requests must be submitted directly to Health Net.

Refer to the Prescription Drug Program topic for additional information about coverage for immunosuppressive medications following a Medicare-approved transplant.

Transplant at a Distant Location

Health Net's provision of a transplant service at a distant location, farther away than normal community patterns of care for transplant services, depends on the local cost of transplant:

- If a Medicare-approved local transplant provider, within normal community patterns of care for transplants, is not willing to cover a transplant for a Health Net member at a mutually agreed-upon payment rate, then Health Net offers the transplant through an alternative Medicare-approved transplant provider.
- If a Medicare-approved local transplant provider, within normal community patterns of care for transplants, is willing to cover a transplant for a Health Net member at the original Medicare fee-for-service (FFS) rate or at a mutually agreed-upon rate, then, although Health Net may offer the transplant at a distant Medicare-approved location, Health Net allows the member the option of obtaining the transplant services locally.

When providing a covered transplant service at a distant Medicare-approved location, farther away than the normal community patterns of care for transplants, Health Net ensures that the Medicare-approved distant location provides at least the same quality and timeliness of services as local providers of this service. More specifically, the wait time for the transplant at the distant Medicare-approved transplant center location cannot be significantly longer than the wait time within normal community patterns of care.

In any circumstances in which Health Net provides transplant services at a distant location, Health Net may provide reasonable accommodations for the member and a companion while at the distant location depending on the member's Evidence of Coverage (EOC) description.

Transplant Travel Expenses

Health Net offers qualified transplant travel expenditures for Health Net Medicare Advantage members who are sent out of their service area for transplants. Prior authorization is required, and a Health Net case manager determines the set guidelines for lodging based on the member's benefit plan guidelines. Once approved and travel is completed, a member will need to fill out a Medicare Advantage Member Claim Form (PDF) for review and possible reimbursement based on pre-approved services. Providers can refer to the member's EOC or Member Handbook for specific coverage details.

Compliance for Transplant Performance Centers Standardized Process

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

Designated Transplant Network Participation

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

Annual Transplant Program Review

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

Data Submission

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

Transplant Program Change Notification

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

Performance Requirements

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

Required Accreditation

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

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

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

Two Levels of Participation –

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

Volume Criteria

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

Minimum Transplant Volume required per calendar year:

Transplant Type	Adult	Pediatric
Kidney	30	3
Liver	15	3
Heart	12	2
Lung	12	1
Pancreas or SPK	No minimum if kidney meets	N/A
Intestinal/Small Bowel	3	1
Blood and Marrow	40 total, with at least 20 being allogeneic	10

Survival/Outcomes Criteria:

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

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

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

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

Blood and Marrow –

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

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

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

Health Net Transplant Performance Centers

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

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

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

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.

Transportation

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

Wellcare By Health Net contracts with Access2Care™ to provide routine transportation services benefits with no charge to members when covered by their plan. Refer to the member's Schedule of Benefits or Evidence of

Coverage (EOC) for specific information on plan coverage and exclusions. For additional information or to request routine transportation service, members can be directed to the Health Net Transportation Vendors.

D-SNP members who exhaust their Medicare transportation benefits can contact Member Services to coordinate their Medi-Cal transportation benefits through an applicable vendor.

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
- Exclusions and Limitations

Overview

Participating Physician Groups (PPG)

Wellcare By Health Net's vision plan is an option available to some Health Net employer groups and individual plan members. Wellcare By Health Net contracts with Premier Eye Care to provide vision benefits to some Health Net Medicare Advantage (MA) plan members. Refer to the member's Evidence of Coverage (EOC) or Schedule of Benefits for covered services.

Supplemental vision coverage Wellcare By Health Net may offer additional supplemental vision coverage to some plan members which is administered by Premier Eye Care. Refer to the member's Evidence of Coverage (EOC) or Schedule of Benefits for covered services. Medicare Part B vision services can be found at the links below:

- Routine eye exams
- Eyeglasses and contact lenses
- Glaucoma screenings
- Cataract surgery
- Eye exams (for diabetes)

Under the vision plan, if the member requires eyeglasses, a prescription is written, and the member may purchase eyewear through Premier Eye Care. **Refractive lenses cataract surgery**Lenses following cataract surgery are covered by the medical plan. Refractive lenses are covered when they are medically necessary to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens due to surgical removal or congenital absence. Under Medicare guidelines, one pair of contact lenses or

eyeglasses is covered following each cataract surgery in addition to the surgically implanted intraocular lens (IOC).

Exclusions and Limitations

Provider Type: Physicians | Participating Physician Groups (PPG)

The following are not covered:

- Two pair of glasses instead of bifocals
- Replacement of lenses, frames or contact lenses
- Medical or surgical treatment
- Orthoptics
- Vision training or supplemental testing
- Other insurance policies or service agreements
- Artistically painted non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

A full description of the vision benefit is included in the member's Evidence of Coverage (EOC).

X-Ray and Laboratory Services

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

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

Select any subject below:

- Overview
- Clinical Laboratory Improvement Amendments Requirements
- Diagnostic Procedures
- Laboratory Services
- Radiation Therapy

Overview

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

Medically necessary X-ray and laboratory procedures, services and materials are covered when ordered or approved by the participating provider.

Exclusions and Limitations

X-ray and laboratory procedures associated with routine physical examinations for insurance are not covered on most plans. These procedures are also not covered when obtained for licensing, employment, school, camp, or other non-preventive purposes. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms is not.

Additionally, premarital blood tests are not covered.

Clinical Laboratory Improvement Amendments Requirements

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

The Centers for Medicare and Medicaid Services (CMS) regulates laboratory testing through Clinical Laboratory Improvement Amendments of 1988 (CLIA). CLIA regulations require facilities to be appropriately certified for each test they perform, including waived tests, on materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings.

CLIA ensures quality laboratory testing and requires all laboratory testing sites to have one of the following certificates to legally perform clinical laboratory testing:

- Certificate of Waiver (COW)
- Certificate of Registration
- Certificate of Accreditation
- Certificate for Physician-Performed Microscopy Procedures (PPMP)
- Certificate of Compliance

CLIA CERTIFICATION NUMBER

Providers must include the CLIA certification number when submitting laboratory claims with applicable HCPCS codes to Health Net in order for claims to be paid. For some clinical waived laboratory tests, providers must submit unique HCPCS procedure codes with a modifier QW, which denotes a CLIA waiver.

HCPCS codes for clinical laboratory tests under CLIA regulations change each year. CMS provides an updated listing of new HCPCS codes that are subject to CLIA edits, waived from CLIA edits and discontinued. A current listing of HCPCS codes is available online at CMS.

Diagnostic Procedures

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

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

Evolent Specialty Services Agreement

Evolent Specialty Services Agreement provides UM determinations for the following outpatient imaging procedures:

- Advanced imaging:
  - Computed tomography (CT)/computed tomography angiography (CTA)
  - Magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA)
  - Positron emission tomography (PET) scan
- Cardiac imaging:
  - Coronary computed tomography angiography (CCTA)
  - Myocardial perfusion imaging (MPI)
  - Multigated acquisition (Muga) scan
  - Stress echocardiography
  - Transthoracic echocardiography (TTE)
  - Transesophageal echocardiography (TEE)

Exceptions

Health Net retains responsibility for UM determinations for these services.

- Emergency room radiology services

Laboratory Services

Provider Type: Physicians

Quest Diagnostics® and LabCorp® are Health Net's preferred providers are Health Net's preferred provider for laboratory services for the following lines of business:

- Point of Service (POS)
- PPO
- EPO
- Fee-for-service (FFS):
  - HMO

- Medicare Advantage (MA)
- Medi-Cal

Quest Diagnostics is the world's leading provider of diagnostic testing, information and services, and offers:

- Convenient access to testing services with over 400 Quest Diagnostics Patient Service Center (PSC) locations in California, in addition to an online PSC locator and appointment scheduling function to minimize wait times.
- Access to more than 3,000 clinical, esoteric and anatomic pathology tests performed at one of Quest Diagnostics' testing facilities.
- Industry-leading standards of quality, integrity and clinical excellence, providing the greatest level of consistency and security for providers' practices.
- Consultation services with more than 800 physician and clinical specialists for rare or difficult test results.
- 24-hour-a-day, seven-day-a-week access to electronic laboratory orders and results, and other office solutions through Care360® Labs & Meds.
- Electronic prescription capability to order and renew prescriptions.
- Patient-friendly reports that help easily explain test results.

Radiation Therapy

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

eviCore healthcare is responsible for the prior authorization process for radiation therapy for all members*. Physicians and specialty providers can request prior authorization by contacting eviCore healthcare.

*Health Net continues to review radiation therapy requests for Direct Network HMO (including Ambetter HMO) until Department of Managed Healthcare (DMHC) approval is received.

Claims and Provider Reimbursement

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

This section describes claims and provider reimbursement

Select any subject below:

- Remittance Advice and Explanation of Payment System
- Accessing Claims on the Health Net Provider Portal
- Adjustments
- Balance Billing
- Billing and Submission
- Capitated Claims Billing Information

- Claims Processing for DSNP in EAE Counties
- Eligibility and Capitation
- Eligibility Guarantee
- Fee-For-Service Billing and Submission
- Telehealth Billing Requirement
- Institutionalized Members
- Medicare Risk Adjustment Report
- Payment for Service of Non-Participating Providers
- Professional Claim Editing
- Professional Stop Loss
- Provider Participation Agreement
- Refunds
- Reimbursement
- Reinsurance
- Schedule of Benefits and Summary of Benefits
- Shared Risk
- When Medicare is a Secondary Payer

Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

The remittance advice (RA) and explanation of payment (EOP) system communicates Health Net's claims resolution and outcomes to participating hospitals. This automated system consolidates claim payments to providers and recognizes and recovers any overpayment allowed under the provider's contract.

Hospitals receive a RA and EOP from Health Net when any of the following occurs:

- Health Net pays, denies or contests a claim for services provided to a Health Net member
- For Medicare employer groups withholds a payment to recover a previous overpayment. A RA and EOP overpayment detail notification is sent to the provider. This notification does not apply to individual Medicare or Special Needs Plan (SNP) providers.

A RA and EOP notification lists payments Health Net makes to hospitals claim by claim. It is composed of the following:

- Subscriber identification number
- Patient name
- Patient account number - recorded on the CMS-1500 or UB-04
- Health Net claim identification (ID) number
- Service dates
- Total billed
- Contract adjustment
- Amount paid - same as contract adjustment
- Total claims payable

- Total check amount - total claims payable

Hospitals must carefully review all RA and EOP notifications to verify payments and denials. Health Net does not send letters on initial claim denials. Questions regarding RA and EOP notifications must be directed to the Provider Services Center.

Accessing Claims on the New Health Net Portal

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

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

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

Adjustments

Provider Type: Physicians | Ancillary

If a participating provider believes that a claim was processed inaccurately and wants to request an adjustment, the claim may be resubmitted to Health Net requesting reconsideration of the claim by following the provider dispute resolution process.

Balance Billing

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

Balance billing is strictly prohibited by state and federal law and Health Net's Provider Participation Agreement (PPA).

Balance billing occurs when a participating provider bills a member for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for such services denied by Health Net or the affiliated participating physician group (PPG). Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept Health Net's fee for these services as payment in full, except for applicable copayments, coinsurance, or deductibles.

Dual Special Needs Plan (D-SNP) members are not subject to copayments, so providers must not charge D-SNP members coinsurance, copayments, deductibles, financial penalties, or any other amount due to their Medi-Cal eligibility. Any amounts non-covered by the Medicare payment/reimbursement must be sent for secondary payment to the member's Medi-cal managed care plan (MCP) or directly to the Department of Health Care Services (DHCS) if not assigned to a Medi-cal MCP for that date of service.

Providers can verify the member's Medi-cal MCP by checking the Medi-Cal Automated Eligibility Verification (PDF).

Providers can refer to the Verifying and Clearing Share-of-Cost section for information regarding D-SNP members' share of cost (SOC) responsibility for certain services.

Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered. A participating provider who exhibits a pattern and practice of billing members will be contacted by Health Net and is subject to disciplinary action.

For more information, select any subject below:

- Billing Medicare/Medi-Cal Members Prohibited
- Hold Harmless Provisions

Billing Medicare/Medi-Cal Members Prohibited

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

Providers are prohibited from collecting Medicare Parts A and B deductibles, coinsurance or copayments from members enrolled in the qualified Medicare beneficiaries (QMB) program, which exempts members from

Medicare cost-sharing liability. Providers can either accept the Health Net payment as payment in full or bill the state for applicable Medicare cost-sharing for members who are eligible for both Medicare and Medicaid.

This prohibition applies to all Medicare Advantage (MA) providers, not only those that accept Medicaid. In addition, balance billing restrictions apply regardless of whether the state Medicaid agency is liable to pay the full Medicare cost-sharing amounts.

Hold Harmless Provisions

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

In accordance with standards established by the Centers for Medicare and Medicaid Services (CMS), under the terms of the provider participation agreements (PPAs), participating providers agree to hold the member harmless, and protect the member from incurring financial liabilities that are the legal obligation of a Medicare Advantage Organization (MAO) or its' participating providers. In no event, including but not limited to, nonpayment, termination, non-renewal, insolvency or breach of an agreement by Health Net, shall the provider, or any intermediary, bill charge, collect a deposit from or receive other compensation or remuneration from a member. Participating providers cannot take any recourse against a member, or a person acting on behalf of a member, for services provided.

This provision does not prohibit the following:

- Collection of applicable coinsurance, deductibles, or copayments, as specified in the member's Evidence of Coverage (EOC).
- Collection of fees for non-covered services, provided that the member was informed in advance, and in writing of the cost and elected to have non-covered services rendered.

Billing and Submission

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

This section contains general information on claims billing and submission.

Select any subject below:

- Claims Submission
- Claims Submission Requirements
- Clinical Information Submission
- CMS-1500 Billing Instructions
- Hospital Acquired Conditions
- Timely Claims Submission
- Trauma Services
- UB-04 Billing Instructions

Claims Submission

Provider Type: Participating Physician Groups (PPG) | Hospitals

The claim information listed below is required when submitting a professional stop loss, eligibility guarantee, or insured services claim. A copy of the original itemized bill or invoice must accompany the participating physician group (PPG) Professional Claim form. This information is required for the claim to be processed.

In accordance with the Provider Participation Agreement (PPA) Addendum, PPGs agree to pay claims promptly according to the Centers for Medicare & Medicaid Services (CMS) standards and comply with all payment provisions of state and federal law. CMS requires participating provider claims to be paid within 60 calendar days of receipt. PPGs also agree to include specific payment and incentive arrangements in agreements with all downstream providers.

Only one type of claim may be submitted per form.

Field Name	Required Information
Patient Name	The member's name as it appears on the Eligibility Report.
Subscriber ID Number	The subscriber ID number under which the member is covered.
Subscriber Name	The first and last name of the employee who is enrolled in Health Net as it appears on the Eligibility Report.
Member Code	An internal Health Net three-digit member code that identifies the member. This field may be left blank.
PPG Name	The name of the PPG in which the member is enrolled. This field may be left blank.
PPG #	The PPG's Health Net identification number.
Type of Claim	CMS-1500 or UB-04 (CMS-1450)

Field Name	Required Information
For Health Net Use Only	Do not write in the shaded columns. This space is used by Health Net to calculate eligible benefits. On computerized billing forms do not use the section titled "Insurance Company."
Date of Service	The date on which an individual service was provided to a member. Do not indicate one date and "10 visits."
RBRVS Code	The RBRVS and CPT/HCPCS code (billing codes). Do not use codes created for internal use by the PPG. These unique codes are not accepted by Health Net.
Description	English language description of the submitted RBRVS and CPT/HCPCS code. Do not use a PPG-substituted description.
Charges	The amount a fee-for-service member would be charged.
Doctor Number	Provider's tax identification number and National Provider Identifier (NPI) number.
Third Party	Any amounts collected by the PPG for COB (Medicare or other indemnity carriers). Claims should not be submitted until the other carriers are billed and a response is received.
Diagnosis	The ICD-10 code or the English language description of the illness or disease for which the patient is being treated.

Additional information may be required under certain circumstances.

Claims Submission Requirements

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

Health Net encourages providers to submit claims electronically. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. Claims missing the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return. Nonstandard forms include any that have been downloaded from the Internet or photocopied, which do not have the same measurements, margins, and colors as commercially available printed forms.

Refer to un-clean claims for more information.

Acceptable Forms

For paper claims, Health Net only accepts the Centers for Medicare & Medicaid Services (CMS) most current:

- CMS-1500 form - complete in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, updated each July.
- CMS-1450 (UB-04) form - complete in accordance to UB-04 Data Specifications Manual, updated each July.

Other claim form types will be upfront rejected and returned to the provider. Providers should adhere to the claims submission requirements below to ensure that submitted claims have all required information, which results in timely claims processing.

Electronic Claims

For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction. Each claim submitted must include all mandatory elements and situational elements, where applicable. Secondary COB claims can be sent electronically with all appropriate other payer information and paid amounts.

Paper Claims

Paper claim forms must be typed in black ink with either 10 or 12 point Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Claims submitted on black and white, handwritten or nonstandard forms will be rejected and a letter will be sent to the provider indicating the reason for rejection. To reduce document handling time, providers must not use highlights, italics, bold text, or staples for multiple page submissions. Copies of the form cannot be used for submission of claims, since a copy may not accurately replicate the scale and optical character recognition (OCR) color of the form.

Health Net only accepts claim forms printed in Flint OCR Red, J6983 (or exact match) ink and does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

Professional Claims

Providers billing for professional services and medical suppliers must complete the CMS-1500 (02/12) form. The form must be completed in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual Version 5.0 7/17 at www.nucc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Institutional Claims

Providers billing for institutional services must complete the CMS-1450 (UB-04) form. The form must be completed in accordance with the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2018 at www.nubc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Medicare Billing Instructions

Medicare CMS-1500 and completion and coding instructions, are available on the CMS website at www.cms.gov.

Mandatory Items for Claims Submission

Refer to CMS-1500 Billing instructions or UB-04 Billing Instructions as applicable for complete description and required or conditional fields.

Reference guide for commonly submitted items

Form Fields	Electronic	CMS-1500	UB-04
Billing provider tax ID	Loop 2010AA REF segment with TJ qualifier	Box 25	Box 5
Billing provider name, address and NPI	Loop NM109 with XX qualifier	Box 33	Box 1

Form Fields	Electronic	CMS-1500	UB-04
Subscriber (name, address, DOB, sex, and member ID required)	2000B and 2010BA	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Provider taxonomy		Box 33B and Box 24	Box 57
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	2000C and 2010CA	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Principal diagnosis and additional diagnoses	Loop 2300 HI segment qualifier BK (ICD9) or ABK (ICD10)	Box 21	Box 66
Diagnosis pointers (up to 4)	Loop 2410 SV107	Box 24E (A-L)	N/A
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76
Rendering provider	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)	NPI in Box 24J	N/A
Service facility information	Loop 2310C or 2310E NM1 with 77 qualifier (if differs from billing provider)	Box 32	N/A
Procedure code	Loop 2400 SV segment	Box 24D	Box 44 if applicable

Form Fields	Electronic	CMS-1500	UB-04
NDC code	Loop 2410 LIN segment with N4 qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
UPN	Loop 2410 LIN segment with appropriate UP, UK, UN qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
Value codes (for accommodation codes, share of cost, etc.)	Loop 2300 HI segment with qualifier BE	N/A	Box 39, 40, 41
Condition codes	Loop 2300 HI segment with qualifier BG	N/A	Box 18-28
COB-other subscriber or third party liability	Loop 2320, 2330A and 2330 B	Box 9, if applicable (requires paper EOB from other payer), 10, 11	Box 50-62 (requires paper EOB from other payer)
Claim DOS	Loop 2400 DTP segment with 472 qualifier	Box 24A	Box 45 for outpatient when required
Claim statement date	Loop 2300 with 434 qualifier	N/A	Box 6 from and through

Claims Rejection Reasons and Resolutions

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

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
01	Member's DOB is missing or invalid	Enter the member's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10	Section 2 [1]Non-standard submission or equivalent
02	Incomplete or invalid member information	Enter the member's Health Plan member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social Security number (SSN) should not be used. Check eligibility online, electronically, or refer to the member's current ID card to determine ID numbers	CMS-1500 box 1a UB-04 box 60	Section 2 [1]Non-standard submission or equivalent
06	Missing/invalid tax ID	Include complete 9-character tax identification number (TIN)	CMS-1500 box 25 UB-04 box 5	Section 1a [1]Non-standard submission or equivalent
17	Diagnosis indicator is missing POA indicator is not valid DRG code is not valid	Ensure 9/0 ("9" for ICD-9 or "0" for ICD-10) appears in field 66 for all claims. Ensure present on admission (POA) indicators	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		are valid when billed. Ensure a valid DRG code is used in field 71. POA valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at time of inpatient admission. Leave blank if cannot be determined		
75	The claim(s) submitted has missing, illegible or invalid value for anesthesia minutes	When box 24 is completed, then box 24G must be completed as well	CMS-1500 box 24D and 24G	N/A
76	Original claim number and frequency code required	When submitting a corrected claim, for UB-04 box 64 and CMS-1500 box 22, you must reference the original claim. Claim numbers can be found on your Remittance Advice (RA)/ Explanation of Payment (EOP)	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		or check claims status online. Do not include punctuation, words or special characters before or after the claim number. Submission ID from a reject letter is not a valid claim number. If not using frequency codes 7 or 8 leave boxes 64 and 22 blank. Submit contested claims to Medi-Cal Provider Contested Claims.		
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit –	UB-04 box 4	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)		
87	One or more of the REV codes submitted is invalid or missing	Include complete 4-digit revenue code	UB-04 box 42	N/A
92	Missing or invalid NPI	Enter provider's 10-character National Provider Identifier (NPI) ID	CMS-1500 box 24J and 33A UB-04 box 56	Section 1b [1]Non-standard submission or equivalent
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any of these elements are missing, the claim will reject	CMS-1500 box 24D UB-04 box 43	N/A
A7	Invalid/missing ambulance point of pick- up ZIP Code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pickup (POP) ZIP in box 23 in addition to the addresses in 24	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
			shaded area or box 32	
A9	Provider name and address required at all levels	Include complete provider billing address including city, state and ZIP Code	CMS-1500 box 33 UB-04 box 1	Section 1a [1]Non-standard submission or equivalent
AK	Original claim number sent when the claim is not an adjustment	When submitting an initial claim, leave CMS 1500 box 22 and UB-04 box 64 blank. Any values entered in these boxes will cause a claim to reject.	CMS-1500 box 22 UB-04 box 64	Section 4 [1]Non-standard submission or equivalent
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank. (for description see Reject code 17)	UB-04 box 67–67Q and 72A–72C	N/A
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
C6	Other Insurance fields 9, 9a, 9d, and 11d are missing appropriate data	If the member has other health insurance, box 9, 9a and 9d must be populated, and box 11d must be marked as yes. If this is not provided, the claim will be rejected	CMS-1500 box 9, 9a, 9d and 11d	N/A
AV	Patient's reason for visit should not be used when claim does not involve outpatient visits	Include patient reason for visit for bill type 013x, 078x, and 085x (outpatient) when Type of Admission/Visit (Box 14) is 1 (emergency), 2 (urgent) or 5 (trauma) and revenue code 045x, 0516 or 0762 are reported. Otherwise, do not populate	UB-04 box 70a, b, c	N/A
HP	ICD-10 is mandated for this date of service	Submit with the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms according to the 5010 Guidelines requirement to bill this information. (for	CMS-1500 box 21 UB-04 box 66	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		description see Reject code 17)		
RE	Black/white, handwriting or nonstandard format	Use proper CMS-1500 or UB-04 form typed in black ink in 10 or 12 point Times New Roman font	N/A	N/A

[1]This is not a standard claim form like the CMS-1500 or the UB-04 claim forms; used to bill ECM and Community Supports services only.

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net routinely requires Medicare employer groups to include clinical information at the time of claim submission as follows:

- Evaluation and Management Services (E&M) - There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E&M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E&M services is appropriate. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The documentation of each patient encounter should include the following:

- Reason for the encounter and relevant history, physical examination findings, and any prior and additional diagnostic test results.
- Assessment, clinical impression or diagnosis.
- Medical plan of care.
- Date and legible identity of the observer.
- Any additional relevant information.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill higher level of evaluation and management service when a lower level of service is warranted.

Health Net reserves the right to request clinical records before or after claim payment to identify possible fraudulent or abusive billing practices, as well as any other inappropriate billing practice not consistent or

compliant with the American Medical Association (AMA) CPT codes or guidelines, provided there is evidence such an investigation is warranted.

CMS-1500 Billing Instructions

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

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		box to indicate the patient's sex/gender. M= Male or F= Female	
4	Insured's name	Enter the subscriber's name as it appears on the member's ID card	Conditional - Needed if different than patient
5	Patient's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line - In the designated block, enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP +4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic	Conditional

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		837 Professional 4010A1	
8	Reserved for NUCC	N/A	Not required
9	Other insured's name (last name, first name, middle initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
9a	Other insured's policy or group number	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan	Conditional REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan
9b	Reserved for NUCC	N/A	Not required
9c	Reserved for NUCC	N/A	Not required
9d	Insurance plan name or program name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name	Conditional REQUIRED if field 9 is completed
10 a, b, c	Is patient's condition related to:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		information must then be shown in box 11	
10d	Claims codes (designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code	Conditional
11	Insured policy or FECA number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If box 10 a, b or c is marked Y, this field should be populated	Conditional REQUIRED when other insurance is available
11a	Insured date of birth and sex	Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank	Conditional
11b	Other claims ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number For worker's compensation of property and casualty: Required if known.	Conditional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Acquired Conditions

Provider Type: Hospitals

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

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

Billing Instructions

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

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

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

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

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

Indicator	Description
	determine the appropriate indicator must be made

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

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

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

Quality Improvement HAC Program

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

HAC Confirmation

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

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

HAC Notification

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

Timely Claims Submission

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

Participating providers must submit claims within 120 calendar days after the date of service or as defined in the Provider Participation Agreement (PPA). Where Health Net is the secondary payer under coordination of benefits (COB), the 120-day period begins when the primary payer has paid or denied the claim.

When Health Net requests additional information regarding a claim, participating providers have 60 calendar days from the date of the request to submit the requested information. The remittance advice (RA) and explanation of payments (EOP) must be submitted with the requested information.

If a claim is not submitted within 60 calendar days, or the requested information is not returned to Health Net within 60 calendar days, the claim will be denied and the participating provider does not have the right to submit or resubmit the claim.

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

Field number	Field description	Instruction or comments	Required, conditional or not required
3a	Patient control no	Enter the facility patient account/control number	Not required
3b	Medical record number	Enter the facility patient medical or health record number	Required
4	Type of bill	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	
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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. 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.

Field number	Field description	Instruction or comments	Required, conditional or not required
13	Admission hour	Enter the time using two-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a..m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 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.	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.
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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 2 - Urgent • 3 - Elective • 4 - Newborn • 5 - Trauma	
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):	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 1 - Normal delivery • 2 - Premature delivery • 3 - Sick baby • 4 - Extramural birth • Information not available	
16	Discharge hour	Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 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

Field number	Field description	Instruction or comments	Required, conditional or not required
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: • 01 - Routine discharge • 02 - Discharged to another short-term general hospital • 03 - Discharged to SNF • 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)	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 20 - Expired or did not recover • 30 - Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown (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	

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility 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	Conditional REQUIRED when condition codes are

Field number	Field description	Instruction or comments	Required, conditional or not required
		relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual	used to identify conditions relating to the bill that may affect payer processing
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).	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
		For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence date: REQUIRED when applicable or when a corresponding occurrence code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYY format	
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.	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
		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.	
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).	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
		Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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	
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.	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service

Field number	Field description	Instruction or comments	Required, conditional or not required
		Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/ HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/ HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract	line revenue code billed
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

Field number	Field description	Instruction or comments	Required, conditional or not required
46 lines 1-22	Service units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed	Required
47 Lines 1-22	Total charges	Enter the total charge for each service line	Required
47 Line 23	Totals	Enter the total charges for all service lines	Required
48 Lines 1-22	Non-covered charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts	Conditional - Enter the noncovered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts
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.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Line A refers to the primary payer; B, secondary; and C, tertiary	
51 A-C	Health plan identification number	N/A	Not required
52 A-C	REL information	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'	Required
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to 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

Field number	Field description	Instruction or comments	Required, conditional or not required
56	National Provider Identifier or provider ID	REQUIRED: Enter providers 10-character NPI ID	Required
57	Other provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider	Required
58	Insured's name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial	Required
59	Patient relationship	N/A	Not required
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

Field number	Field description	Instruction or comments	Required, conditional or not required
63	Treatment authorization code	Enter the prior authorization or referral when services require precertification	Conditional - Enter the prior authorization or referral when services require precertification
64	Document control number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line Applies to claim submitted with a type of bill (field 4), frequency of "7" (replacement of prior claim) or type of bill, frequency of "8" (void/cancel of prior claim). *Please refer to the reconsider/corrected claims section	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Payer from field 50
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

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

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" codes and most "V" are NOT 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

Field number	Field description	Instruction or comments	Required, conditional or not 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 principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	Conditional - Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY)
74 a-e	Other procedure code date	REQUIRED on inpatient claims when a procedure is 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	Conditional REQUIRED on inpatient claims when a procedure is performed during the date span of the bill

Field number	Field description	Instruction or comments	Required, conditional or not required
		the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	
75	Unlabeled field	N/A	Not required
76	Attending physician	Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following qualifier and ID number: • 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name.	Required

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

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

Field number	Field description	Instruction or comments	Required, conditional or 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: Participating Physician Groups (PPG) | Hospitals | Physicians | 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

#	Field	Description
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
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

#	Field	Description
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
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

#	Field	Description
22.	Billed Amt	The amount billed for a claim line

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

Plan-Risk or Shared-Risk Claims

Plan-risk or shared-risk claims must be sent to Health Net for adjudication. Attach a copy of the Plan/Shared-Risk Cover Sheet to each group of claims the provider submits. Additionally, the claims should be separated and batched into plan or shared-risk services and claim types. All claims submitted to Health Net must be on CMS-1500, LTC form 25-1 or UB-04 claim forms, and must indicate the date of receipt by the participating physician group (PPG). Claims for plan-risk or shared-risk services must be submitted to Health Net.

The following information must be included on every claim:

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

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

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

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

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

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

For more information, select any subject below:

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

Excessive Fees by Hospital-Based Providers

Provider Type: Participating Physician Groups (PPG)

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

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

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

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

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

1. Determine whether complications or other factors justify the charge. If there is justification, pay the amount billed and end the process. If there is no justification, proceed to the next step.
2. Contact the provider and attempt to resolve the difference. If there is no resolution, proceed to the next step.
3. Pay all outstanding charges, but notify the provider that this is being done under protest and that the PPG intends to seek a peer review of the matter by the local medical society.
4. Call the California Component Medical Societies for assistance in selecting the appropriate California county medical society to hear the protest. The correct county medical society is the one located in the same geographical area as the provider whose charge is in dispute.
5. Call the county medical society and ask for instructions for submitting cases for peer review.
6. If the PPG is informed that a member has been contacted by a collection agency, in addition to paying all outstanding charges, inform the collection agency in writing that the PPG is responsible for paying for the service and that the PPG has made payment, but that the validity of the charge is in dispute. State that the disputed excessive fee is to be subjected to a medical society peer review. Request that, in view of these facts, the collection agency take no action that might impair the credit rating of the member.

Shared-Risk Claims

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

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

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number, which is located on the member's ID card
- Provider name and address
- ICD-10 diagnosis code
- Service dates
- Billed charge per service
- Current year CPT procedure or U-92 (CMS-1450) revenue code
- Place of service or UB-92 or UB-04 bill type code
- Submitting provider tax identification number and national provider identifier (NPI) number
- Member name and date of birth as indicated on the member ID card
- State license number of the attending provider

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

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

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

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.

Eligibility and Capitation

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

This section includes general information on member eligibility and capitation.

Select any subject below:

- Capitation Payments
- Capitation Rates
- Dual Risk
- Electronic Capitation Reports
- Hospital Liability Payment
- PPG Liability Payments
- Professional Stop Loss Levels
- Reports

Capitation Payments

Provider Type: Participating Physician Groups (PPG) | Hospitals

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

Capitation Rates

Provider Type: Participating Physician Groups (PPG)

The capitation rate is a percentage of the Centers for Medicare & Medicaid Services (CMS) premium negotiated between Health Net and the provider. Refer to the Provider Participation Agreement (PPA) for reimbursement information. The rate for the current calendar year applies to individual members and members of each employer group.

Dual Risk

Provider Type: Participating Physician Groups (PPG) | Hospital

The dual-risk program is an optional program in which the participating physician group (PPG) establishes a capitated incentive arrangement with a primary hospital that is capitated and financially responsible for in-area hospital services provided to Health Net members. Hospitals are liable for in and out-of-area services up to the reinsurance limit. This program is only offered to a limited group of PPGs and hospitals.

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

Electronic Capitation Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net provides commercial, Medicare Advantage (MA) capitation reports to capitated participating physician groups (PPGs) and hospitals on five electronic media files - Eligibility, Activity Analysis, Remittance Detail, Eligibility Summary by Group, and SB 260 Reconciliation Report.

Eligibility File

The Eligibility file lists all members eligible for benefits for at least one day in the month. It contains member information, including names, addresses, plan codes, and benefit information. Capitation amounts are not included in the file, but may be listed in the Remittance Detail file. The Eligibility file is sorted by the member's last name. All records in this file are 224 bytes long. There are four record types: header, detail, coordination of benefits (COB), and trailer. Data expressed in the X format is left-justified and blank-filled, data expressed in the nine format is right-justified and zero-filled.

Activity Analysis File

The Activity Analysis file provides non-dollar activity, such as additions and cancellations of members, and should be used to update members' files, including retroactive adjudication of affected claims. It also reflects changes to a member's status, such as plan code, address and effective date. Multiple transactions for a member are sorted by prioritization of activity codes and report by prioritization. The Activity Analysis file is sorted by the member's last name. All records in the file are 279 bytes long. There are three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank-filled. Data expressed in the nine format is right-justified and zero-filled.

Remittance Detail File

The Remittance Detail file provides capitation remittance amounts per member. The amount reflected consists of the current month capitation amount plus any adjustments made in the current month for retroactivity. The Remittance Detail file is sorted by the member's last name. All records in this file are 157 bytes long. There are three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank- filled. Data expressed in the nine format is right-justified and zero-filled. All dollar amount fields are signed (-, +) and contain assumed decimals.

Eligibility Summary by Group File

The Eligibility Summary by Group file lists all employer groups with active members enrolled with a specific provider for the month being reported. This file is sorted by the employer group name. All records in this file are 142 bytes long. This file has three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank-filled. Data expressed in the nine format is right-justified and zero-filled.

SB 260 Reconciliation Report

The SB 260 Reconciliation Report provides enrollment and capitation payment summary at the product level for the prior 18 months. All records in this file are 1024 bytes long. This file has three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank-filled. Data expressed in the nine format is right-justified and zero-filled.

Internet Transmission

Health Net also offers providers these five capitation reports through the Internet to help reconcile eligibility and remittance payments. PPGs and hospitals that request their capitation reports online are allowed to test their files for a period of up to two months and still receive hard copy reports. After this two-month testing period, hard copy reports are no longer sent. With the exception of this testing period, only one format of reports is provided. If PPGs or hospitals are interested in receiving capitation files in this format, they should contact their provider relations and contracting specialists for details.

Hospital Liability Payment

Hospitals

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

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

liability claims that Health Net pays on behalf of the primary hospital are deducted from the monthly hospital services capitation.

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

PPG Liability Payments

Participating Physician Groups (PPG)

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

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

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

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

Professional Stop Loss Levels

Participating Physician Groups (PPG)

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

Reports

Provider Type: Participating Physician Groups (PPG)

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

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

The following reports are available to PPGs:

Report #	Name	Description
BRM 11	Eligibility Summary by Employer Group Report	Lists members by employer group.
BRM 18	CMS Monthly Membership Report	Lists Medicare-specific attributes and premium amounts.
BRM 20	Remittance Detail Report	Details the capitation and adjustments for each member.
BRM 25	CMS Risk Adjustment Model Output Report	Lists hierarchical condition category (HCC) codes used by the Centers for Medicare & Medicaid Services (CMS) to determine risk scores.
BRM 28	SB260 Reconciliation Report	Summarizes eligibility and remittance data.

Report #	Name	Description
BRM 30 (monthly) or BRW 30 (weekly)	Activity Analysis Report (available weekly or monthly)	Details all member-related activity during the prior reporting period. • **Weekly** report includes only members with a transaction/change – new member adds, transfers, cancellations/ disenrollment, PCP changes, etc.
BRM 42	Expanded Eligibility Report	Lists all members approved by CMS who receive their Medicare benefits from Health Net.

Eligibility Guarantee

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

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

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

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

For more information, select any subject below:

- Request for Payment Submission and Processing

Request for Payment Submission and Processing

Participating Physician Groups (PPG)

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

In addition, the PPG must:

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

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

Eligibility Guarantee Processing

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

Exclusions and Limitations

The following exclusions and limitations apply to eligibility guarantee:

- In order for Health Net to pay the PPG, the PPG must have contacted Health Net to verify eligibility for any member requiring emergency or inpatient hospital care.
- Members who come to the PPG for services without a valid Health Net identification (ID) card must sign an Eligibility Certification form. This form must also be signed if the member is not listed on the most recent Eligibility Report. PPGs should not call Health Net to verify eligibility for services provided within the PPG.
- PPGs do not receive eligibility guarantee payments for current members who transfer into the PPG.
- Health Net limits final eligibility guarantee payments to professional charges (capitated services and insured services).
- If any insured services are provided before the PPG is notified of the member's ineligibility, they are considered subject to eligibility guarantee requests for payment only if they have not been included in claims made to Health Net directly by treating providers through insured service liability.

- If a member is determined by Health Net to have been ineligible at the time of receiving hospital services (or other shared-risk benefits), Health Net is not responsible for payment. The member is liable for these charges.

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 | Participating Physician Groups (PPG) | Hospitals | Ancillary

For electronic claims submissions that apply to providers serving individual Medicare members, check the current member identification (ID) card for the correct payer ID.

The benefits of electronic claim submission include:

- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.
- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

For questions about electronic claims or electronic remittance and explanation of payment for individual Medicare and Special Needs Plan (SNP) member claims, contact the Health Net/Centene EDI Department.

FFS Claims Submission

Provider Type: Physicians

When submitting fee-for-service (FFS) claims, provide all required information accurately. Health Net requires that all FFS professional claims be submitted on the CMS-1500 claim form for Medicare Advantage (MA) HMO,

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

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

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.

Institutionalized Members

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

The Centers for Medicare & Medicaid Services (CMS) determines whether a Medicare Advantage organization (MAO) should be paid at the institutional rate for a member. CMS provides a substantial increase in monthly capitation for qualified institutionalized members when it is reported back to CMS each month that the member remains qualified. The institutional payment is prospective; however, the payment mechanism is retroactive. CMS makes a retroactive payment adjustment two months after the month a member satisfies the residency requirement.

CMS Definitions: Institutionalized and Special Needs Members

If a Medicare Advantage (MA)-eligible member is admitted to a Medicare or Medicaid certified institution and is receiving skilled nursing services, the member is considered skilled until the first 100 days are used. If the member has been admitted and reverted to custodial care after receiving skilled nursing care, or was just admitted as custodial, the member would be classified institutionalized after the first 30 days. The level of care (skilled nursing, rehabilitation, or custodial) does not need to be considered in order for the member to be classified as institutionalized.

A MA eligible member who continuously resides, or who is expected to continuously reside, for 90 days or longer in a skilled nursing facility (SNF) is defined as a special needs member.

Definition - Medicare-Certified Institution

A member can only be classified as institutionalized if the facility in which the member resides is a Medicare (title XVIII) or Medicaid (title XIX) certified institution. These facilities are:

- A skilled nursing facility (SNF), as defined in section 1819(a), primarily engaged in providing skilled nursing care or rehabilitative services to residents. SNFs must have in effect an agreement with a hospital that ensures transfer of patients is affected between the two, whenever such transfer is medically appropriate
- A nursing facility, as defined in section 1919(a), includes a SNF, but also includes institutions that provide health-related care and services to residents who, because of their mental or physical condition, require care and services, which can be made available to them only through institutional facilities
- "Intermediate care facility for the mentally retarded," as defined in section 1905(d), that provides health or rehabilitative services for mentally retarded residents receiving active treatment under Medicaid
- A psychiatric hospital or unit, as defined in section 1866 (d)(1)(B), is an institution, or distinct part of an institution, primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons

- A rehabilitation hospital or unit, as defined in section 1886 (d)(1)(B), is an institution that serves an inpatient population of whom the vast majority require intensive rehabilitative services for the treatment of certain conditions (for example, stroke, amputation, brain or spinal cord injuries, and neurological disorders)
- A long-term care hospital, as defined in section 1886 (d)(1)(B), is a hospital that has an average inpatient length of stay greater than 25 days
- A swing-bed hospital, as defined under section 1883, is a hospital that has entered into an agreement whereby its inpatient hospital facility is furnished by a SNF and would constitute extended care service

In addition to residing in one of the above-listed institutions, the member must be a resident for 30 consecutive days (or 90 for a special needs member) prior to the month the higher institutional rate is paid. This 30 or 90-day period must include the last day of the month (for example, January 2 through January 31). The term "calendar month" cannot be used. A calendar month can have 28 to 31 days and cannot be substituted for 30 days.

Medicare Risk Adjustment Report

Provider Type: Physicians | Participating Physician Groups (PPG)

The Centers for Medicare & Medicaid Services (CMS) requires Health Net to track Medicare Advantage (MA) claims separate from all other claims. For this reason, MA claims are separated from all other claims at the time of receipt. CMS determines MA plan payments based on a two-part calculation - a demographic formula plus a risk-adjustment formula. CMS uses encounter (including claims) data, reported to the health plan from providers, as a source of calculating the "risk adjustment" payment amount.

The risk adjustment formula uses demographic data (for example, age, sex, Medicaid status, or county of residence) and diagnostic data (for chronic conditions) to determine payment. More funds are paid for less healthy members. It also uses the current year's diagnostic data as the basis for next year's payments. Diagnosis of a condition must be reported at least every 12 months to continue payment at that rate. Complete, accurate and timely encounter claims/data reporting is key to receiving full payment from CMS.

Health Net and participating providers are required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data.

Payment for Service of Non-Participating Providers

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

Health Net and its participating physician groups (PPGs) must make timely and reasonable payment to, or on behalf of, Health Net members for the following covered services obtained from non-participating providers:

- Ambulance services dispatched through 911 or its local equivalent.
- Emergency and urgently needed services.
- Maintenance and post-stabilization care services.
- Renal dialysis services provided while the member was temporarily outside the service area.
- Services for which coverage has been denied by Health Net and found upon appeal, to be services the member was entitled to have furnished, or paid for, by Health Net or the PPG.
- Federally Qualified Health Center (FQHC) services if not available in Health Net's or its PPG's network.

Professional Claim Editing

Provider Type: Physicians

For individual Medicare and Special Needs Plans

For individual Medicare and Special Needs Plans (SNP), Health Net has a contractual relationship with ClaimsXten to provide a technology solution for professional claim edit policy management. Using ClaimsXten's services, Health Net has the ability to apply advanced contextual processing for application of edit logic, also uses another editing vendor, HCI/PCI, to perform a secondary review after ClaimsXten.

The process is as follows:

- Customizes and controls the selection of all edit policy.
- Claims are transferred through various interfaces to Cotiviti every night.
- ClaimsXten reviews each claim in the file and renders coding recommendations based on s edit policy.
- After ClaimsXten review, if there are any unedited lines remaining, they are sent to HCI/PCI for a secondary review.
- Once all reviews are complete edit recommendations from the vendors are then applied to the claims.

ClaimsXten and HCI/PCI 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 & 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.

For Medicare Employer Groups

For Medicare employer groups, 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, CMS, AMA and other specialty academies, to provide Health Net with the necessary information to make informed decisions when establishing edit policy.

Professional Stop Loss

Participating Physician Groups (PPG)

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

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

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

Payment Request Submission Requirements

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

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

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

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

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

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

Requests for Payment Processing

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

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

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

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

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

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

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

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

Provider Participation Agreement

Provider Type: Physicians | Participating Physician Groups (PPG)

The Provider Participation Agreement (PPA) between participating physician groups (PPGs) and Health Net complies with the changes made to the Balanced Budget Act of 1997 (BBA) and Operational Policy Letter 98.077 (OPL #77). This includes the addition of sections 1851 through 1859 to the Social Security Act to establish Part C of the Medicare program, known as the Medicare Advantage (MA) program. The BBA amended federal law stating that certain requirements must be included in agreements between MA Organizations (MAOs) and their PPGs.

Health Net of California is an MAO as defined by the BBA, and its PPGs must comply with Medicare laws, regulations, and the Centers for Medicare and Medicaid Services (CMS) instructions. Additionally, PPGs must comply with the MAO's operational procedures as described in the Medicare Advantage Provider Operations Manual. In all instances where the Medicare-required provisions of the downstream provider contract, whether in the MA addendum or otherwise, differ from the PPA and/or the MA Provider Operations Manual, the Medicare-required provisions of the downstream provider contract take precedence.

Downstream Contracts

Downstream contracts are contracts that provider organizations have with other providers.

All contracts that health plans have with their participating providers and all downstream contracts issued by participating providers must be in compliance with the Centers for Medicare & Medicaid Services (CMS) requirements of Medicare Managed Care Manual - Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements. CMS continues to audit provider organization and hospital compliance with these downstream contracting requirements.

Health Net of California, the participating physician group (PPG), and downstream participating providers must comply with Medicare laws, regulations, and CMS instructions. Additionally, participating providers must comply with the MA organization's (MAO's) operational procedures as described in the Medicare Advantage Provider Operations Manual. In all instances where the Medicare-required provisions of the downstream provider contract, whether in the MA addendum or otherwise, differ from the Provider Participation Agreement (PPA) and/or the MA Provider Operations Manual, the Medicare-required provisions of the downstream provider contract take precedence.

Refunds

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

This section contains general information on refunds, including verpayment procedures and third-party liability recovery.

Select any subject below:

- Overpayment Procedures

Overpayment Procedures

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

If a provider is aware of receiving an overpayment made by Health Net including, but not limited to, overpayments caused by incorrect or duplicate payments by Health Net, errors on or changes to the provider billing or payment by another payer who is responsible for primary payment, the provider must promptly refund the overpayment amount to the Health Net Overpayment Recovery Department with a copy of the applicable remittance advice (RA) and explanation of payment (EOP) and a cover letter indicating why the amount is being returned. If the RA and EOP are not available, provide member name, date of service, payment amount, the member identification (ID) number, provider tax ID number, and provider ID number.

A refund to Health Net is necessary when a claim is processed incorrectly and results in an overpayment. When Health Net determines that an overpayment has occurred, Health Net notifies the provider of services in writing 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 provider of service has 30 business days to submit a written dispute to Health Net if the provider does not believe an overpayment has occurred. In this case, Health Net treats the claim overpayment issue as a provider dispute.

If the provider does not dispute the overpayment, the provider of services must reimburse Health Net within 30 business days from the receipt of Health Net's notice, or, as permitted by law, interest begins to accrue at the rate of 10 percent per year beginning with the first day after the 30 business day period.

- Include a copy of the RA and EOP 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, and reason for the overpayment refund. If the RA and EOP are not available, it may take longer for Health Net to process the overpayment refund.

- Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department. If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net, such as AIM, Rawlings, GB Collects, or ORS, the provider should follow the overpayment refund instructions provided by the vendor.

Health Net may recoup uncontested overpayments by offsetting overpayments from payments for a provider's current claims for services if:

- The provider's Provider Participation Agreement (PPA) authorizes it to offset overpayments from payments for current claims for services.
- Otherwise permitted under state laws.

A written notification is sent to the provider of service if an overpayment is recouped through offsets to claim payments. The notification identifies the specific overpayment and the claim ID number.

Hospital Overpayments

If Health Net has incorrectly paid a hospital as the primary rather than as the secondary carrier, attach a copy of the primary carrier's Explanation of Benefits (EOB) with a copy of Health Net's RA and EOP 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:

- Endoscopies Classification Reimbursement

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.

Reinsurance

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

This section includes general information on reinsurance processes.

Select any subject below:

- Hospital Reinsurance
- Shared Risk Reinsurance
- Transfer Reinsurance

Hospital Reinsurance

Provider Type: Hospitals

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

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

When the capitated hospital provides institutional risk services that exceed the applicable hospital reinsurance level per member per calendar year, the hospital submits reinsurance requests for payment to the Health Net Reinsurance Unit. Capitated hospitals are required to purchase reinsurance from Health Net. The cost of hospital reinsurance is deducted from the hospital's monthly capitation, as stated in the PPA. However, if permitted under the hospital's PPA, the hospital may elect to purchase reinsurance from a third party. If a hospital elects to purchase reinsurance from a third party, it must provide Health Net with proof of insurance

acceptable to Health Net in accordance with the PPA. Self-insurance or stated reserves for Incurred But Not Reported (IBNR) is not reinsurance.

Non-Covered items

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

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

Requests for Payment Submission

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

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

Requests for Payment Processing

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

Shared Risk Reinsurance

Provider Type: Participating Physician Groups (PPG)

Health Net shared-risk reinsurance limits the participating physician group's (PPG's) responsibility under the shared-risk program to a negotiated limit for shared-risk services and out-of-area emergency services. Unless otherwise provided in the PPG's Provider Participation Agreement (PPA), the terms of the shared-risk reinsurance program are described below.

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

Out-of-Area Urgent and Emergency Services

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

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

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

Shared-Risk Claims from Treating Providers

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

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

Settlement of Reinsurance

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

Health Net settles costs associated with payments it makes to treating providers under the shared-risk reinsurance program, which exceed the attachment point for a calendar year at the same time Health Net makes the shared-risk settlement. At that time, Health Net identifies costs attributable to members' claims that have exceeded the attachment point and issues a report. Adjustments are made to the PPG's shared-risk budget based on this report.

Transfer Reinsurance

Provider Type: Participating Physician Groups (PPG) | Hospitals

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

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

Cost

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

Exclusions

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

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

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

Thresholds

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

Requests for Payment Submission

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

Schedule of Benefits and Summary of Benefits

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

Health Net's Schedule of Benefits is a summary of services that may be covered under the plan. Benefits listed on the Schedule of Benefits are subject to change. The Schedule of Benefits and Summary of Benefits is updated weekly with new plan, benefit and copayment changes as applicable and can be access on the Health Net provider portal.

Shared Risk

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

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

For more information, select any subject below:

- Shared Risk Settlement
- Shared-Risk Reporting

Shared-Risk Reporting

Provider Type: Participating Physician Groups (PPG)

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

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

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

CLRM02S-ICE Version Shared-Risk Paid Claims Report Dispute

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

Actuarial Injectable Risk Report Dispute

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

Paid Claims Report Field Descriptions

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

Shared Risk Settlement

Provider Type: Participating Physician Groups (PPG)

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

When Medicare is a Secondary Payer

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

Health Net works to coordinate member benefits with identified third-party payers, which may include private and government insurance plans. Medicare is generally the primary payer for a member unless the member's current situation dictates his or her private insurance plan is primary to Medicare, such as when the member is actively employed and covered by an employer group benefit plan. In such cases, and when Medicare has previously paid for services as the primary carrier, Medicare issues a Medicare secondary payer (MSP) recovery demand letter. The demand letter includes the participating provider liability claims and claims details and requests a refund from the employer directly and Health Net indirectly as the employer's designated health plan.

If Health Net determines that the MSP recovery demand contains provider liability claims, Health Net sends the provider's MSP contact a demand letter with detailed instructions for responding to the demand, a spreadsheet listing the claims, and a copy of all claims that require provider intervention. (Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Manuals 100-05 Chapters 1-4)

Providers who have questions, contact the Health Net Provider Services Center or the Medicare Provider Services Center.

Claims Coding Policies

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

This section describes Health Net's claims coding process and policies.

Select any subject below:

- Code Editing

Code Editing

Provider Type: Physicians

The plan uses Health Insurance Portability and Accountability Act (HIPAA)-compliant clinical claims editing software for physician and outpatient facility coding verification. The software detects, corrects and documents coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding rule. When the software identifies a claim that does

not adhere to a coding rule, a recommendation known as an edit is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, the plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify circumstances where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, the plan may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

Current Procedural Terminology (CPT) codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. CPT codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. Level I HCPCS Codes (CPT): This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.
2. Level II HCPCS: The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by Centers for Medicare and Medicaid Services (CMS). Level II HCPCS codes are updated on an annual basis.
3. Miscellaneous/Unlisted Codes: The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing unlisted codes must submit medical documentation that clearly defines the procedure performed, including, but not limited to, office notes, operative report, pathology report, and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the unlisted code. For example, if the unlisted code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.
4. Temporary National Codes: These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered

temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. HCPCS Code Modifiers: Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management (E/M) services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10) Code Set

These codes represent classifications of diseases and related health problems. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes indicate the type of procedure performed on patients and where the service was performed. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims auditing software contains a comprehensive set of rules addressing coding inaccuracies, such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research, etc.

The software applies edits that are based on the following sources.

- CMS, National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include Column one/Column two, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control improper coding leading to inappropriate payment.
- Public domain specialty society guidance (such as, American College of Surgeons, American College of Radiology, and American Academy of Orthopedic Surgeons).
- Medicare Claims Processing Manual.
- NCCI Policy Manual for Medicare Services.
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals).
- CMS coding resources, such as, HCPCS Coding Manual, Medicare Physician Fee Schedule (MPFS), Provider Benefit Manual, MLN Matters and Provider Transmittals.
- AMA resources:
    - CPT Manual
    - AMA Website
    - Principles of CPT Coding

- Coding with Modifiers
- CPT Assistant
- CPT Insider's View
- CPT Assistant Archives
- CPT Procedural Code Definitions
- HCPCS Procedural Code Definitions

- Billing Guidelines Published by Specialty Provider Associations:
  - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims.
- Health plan policies and provider contract considerations.

Code Editing and the Claims Adjudication Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

- Deny: Code editing recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Replace and Pay: Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of the available code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

NCCI Procedure-to Procedure (PTP) Practitioner and Hospital Edits

CMS National Correct Coding Initiative (NCCI) - refer to the CMS website at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. CMS has designated certain combinations of codes that should never be billed together, which are known as PTP or Column one/Column two edits. The column one procedure code is the most comprehensive code and reimbursement for the column two code is subsumed into the payment for the comprehensive code. The column two code is considered an integral component of the column one code.

The CMS NCCI edits consist of PTP edits for physicians and hospitals. Practitioner PTP edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). Hospital PTP edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers, and comprehensive outpatient rehabilitation facilities. While PTP code pairs should not typically be billed together, there are circumstances when an NCCI-associated modifier may be appended to the column two code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

NCCI

MUE for Practitioners, DME Providers and Facilities

The purpose of the NCCI MUE program is to prevent improper payment when services are reported with incorrect units of service. MUEs reflect the maximum units of service that a provider would bill under most circumstances for a single member, on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information, and clinical judgment.

Code Bundling Rules Not Sourced To CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations in which the less comprehensive procedure is considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Evaluation and Management (E/M) Service Editing

CMS publishes rules surrounding payment of an E/M service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0-, 10- or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

E&M services for a major procedure (90-day global period) that are reported one-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

E&M services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

E/M services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing Procedures with MMM

Global periods for maternity services are classified as MMM in the Medicare Physician Fee Schedule (MPFS). E&M services billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered to be bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes billing of two or more procedure codes when a single more comprehensive code should have been billed to accurately represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. A frequency edit will be applied by code auditing software when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example a nurse practitioner and physician billing for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under the health plan. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon per CMS and American College of Surgeons (ACS) guidelines. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS and ACS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

Identifies claims with an add-on CPT code billed without the primary service CPT code. Additionally, if the primary service code is denied, then the add-on code is also denied. This rule also looks for circumstances in which the primary code was billed in a quantity greater than one when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the provider bills several lab tests separately that are included as part of a more comprehensive code. This rule will deny the individual lab test codes and add a service line with the appropriate comprehensive code. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician. In some instances, the original service line will be denied and a new service line added with the appropriate modifier. This does not change the original billing, as the original service line remains on the claim.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are

not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes.
- Deleted Codes: Evaluates claims for procedure codes which have been deleted.
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.
- Age Rules: Identifies procedures inconsistent with member's age.
- Gender Procedure: Identifies procedures inconsistent with member's gender.
- Gender Diagnosis: Identifies diagnosis codes inconsistent with member's gender.
- Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid.

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of clinical validation services is the review of modifiers -25 and -59. Code pairs within the CMS NCCI edit tables with a modifier indicator of "1" allow for a modifier to be used in appropriate circumstances to allow payment for both codes. Furthermore, public domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). MA's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

CMS supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier -59

NCCI states the primary purpose of modifier -59 is to indicate that procedures or non-editing/medical services that are not usually reported together are appropriate under the circumstances. The CPT manual defines modifier -59 as distinct procedural service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other nonservices performed on the same day. Modifier -59 is used to identify procedures/services, other than editing/medical services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or

separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier -59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier -59 related to the portion of the definition that allows its use to describe different procedure or surgery. NCCI guidelines state that providers should not use modifier -59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier -59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

The plan uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier -59 were used appropriately.
- To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS, in the NCCI policy manual, specify that by using a modifier -25 the provider is indicating that a significant, separately identifiable E&M service was provided by the same physician on the same day of the procedure or other service. Additional CPT guidelines state that the E&M service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that if a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000). The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare carriers and A/B Medicare administrative contractor (MAC) processing practitioner service claims have separate edits.

The plan uses the following guidelines to determine whether -25 was used appropriately. If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E&M service.

- The E&M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed.

- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services.
- Other procedures or services performed for a member on or around the same date of the procedure support that an E&M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E&M services.

Claim Reconsiderations Related To Code Editing

Claims appeals resulting from claim editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code edit or edit and request claim reconsideration, you must submit medical documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit or edit will be upheld.

Viewing Claims Coding Edits

Code Editing Assistant

The Code Editing Assistant is a Web-based code editing reference tool designed to mirror how the code editing product(s) evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking Claim Editing Tool in our secure provider portal.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- Proactively determines the appropriate code or code combination representing the service for accurate billing purposes.

The tool will review what was entered, and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.The Code Editing Assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan's provider portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.XX in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.XX in the reference number of the policy.

The majority of clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex code can be viewed on the provider's explanation of payment.

- xE: Procedure Code is Disallowed with this Diagnosis Code(s) Per Plan Policy.

Examples

Policy Name	Clinical Policy Number	Description
Diagnosis of Vaginitis	CP.MP.97	To define medical necessity criteria for the diagnostic evaluation of vaginitis in members ages 13 or older.
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies.
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

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

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

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

Clinical Payment Policy Appeals

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

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

Compliance and Regulations

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

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

Select any subject below:

- Mandatory Data Sharing Agreement
- Reproductive Privacy Act
- Medicare Communications and Marketing Guidelines
- Provider Offshore Subcontracting Attestation
- Approval of Medicare Communications and Marketing Guidelines
- Communicable Diseases Reporting
- Federal Lobbying Restrictions
- Health Net Affiliates
- Material Change Notification
- Nondiscrimination

Mandatory Data Sharing Agreement

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

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

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

Participating entities that must sign a DSA include:

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

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

Reproductive Privacy Act

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

Reproductive rights, privacy and the exchange of information

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

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

State law specifically states:[1]

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

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

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

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

Requirements for providers

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

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

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

Medicare Communications and Marketing Guidelines

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

The Centers for Medicare & Medicaid Services (CMS) Medicare Communications and Marketing Guidelines (MCMG), supplemented by the CMS Marketing Guidance for California Medicare-Medicaid Plans, has specific regulations regarding marketing communications by health plans and their participating providers to Medicare-eligible members as outlined below. Participating providers are required to comply with applicable Medicare laws and regulations and plan policies and procedures.

The MCMG states that CMS is concerned with provider marketing for the following reasons:

- Providers are usually not fully aware of all Medicare health plan benefits and costs
- A provider may confuse the beneficiary if the provider is perceived as acting as an agent of the Medicare health plan, versus acting as the beneficiary's provider. Providers may face conflicting incentives when acting as a Medicare health plan representative, since they know their patients' health status. Desires to either reduce out-of-pocket costs for their sickest patients, or to financially gain by enrolling their healthy patients may result in recommendations that do not address all of the concerns or needs of a potential Medicare health plan enrollee

The MCMG also prohibits participating providers from providing advice to potential enrollees who inquire regarding the selection of one health plan over another. Participating providers should direct members to call the Medicare Sales or Health Net Member Services Department for benefit information and health plan comparisons. This practice protects participating providers from violating CMS regulations regarding provider marketing and allows beneficiaries to get the facts necessary for making the best possible decision regarding their health plan choices.

While providers may assist patients in an objective assessment of their needs and potential options to meet those needs, providers must remain neutral when assisting with enrollment decisions. Additionally, if providers advertise non-health-related items or services, the advertisement must make it clear that the items and services are not covered by the health plan with which the provider is contracting.

Refer to the Approval of Medicare Communications and Marketing Guidelines for additional information on this topic.

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.

Approval of Medicare Communications and Marketing Guidelines

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

The Centers for Medicare & Medicaid Services (CMS) Medicare Communications and Marketing Guidelines (MCMG), supplemented by the Marketing Guidance for California Medicare-Medicaid Plans, the three-way contract, and the Memorandum of Understanding (MOU) provide specific guidance regarding marketing communications to Medicare-eligible members by health plans and their contracting physicians, participating physician groups (PPGs), hospitals, and ancillary providers. Participating providers are required to comply with applicable Medicare and Medicaid laws and regulations, and plan policies and procedures when creating or distributing marketing materials on the plan's behalf, including those materials created solely by providers that mention the plan.

CMS Member Marketing Materials Definition

CMS considers marketing materials to be any informational materials directed to Medicare beneficiaries that:

- Promote any Medicare part C or part D plans offered by the organization, or communicate or explain a Medicare health plan (refer to 42 Code of Federal Regulations (CFR) 422.4.
- Inform members they may enroll or remain enrolled in any Medicare part C or part D plans offered by the organization.
- Explain the benefits of enrollment in any Medicare part C or part D plans, or rules that apply to enrollees.
- Explain how Medicare services are covered under any Medicare part C or part D plans, including conditions that apply to such coverage (refer to 42 Code of Federal Regulations (CFR) 422.2260 and (CFR) 423.2260).

The definition of communications means activities and use of materials to provide information to current and prospective enrollees. Communication materials means all information provided to current and prospective enrollees. Marketing materials are a subset of communications materials. The definition of marketing materials as used in Medicare regulations and guidance, extends beyond the public's general concept of advertising materials, and includes, but is not limited to, notification forms and letters used to enroll, disenroll and communicate with the member on many different membership scenarios.

CMS also considers the Internet another vehicle for the distribution of communications and marketing information. Therefore, all regulatory rules and requirements associated with all other marketing conveyances, such as newspaper, radio, television, and brochures, are also applicable to Medicare Advantage organization (MAO) marketing activity on the Internet. CMS marketing review authority extends to all marketing activities, such as advertising, and pre- and post-enrollment activity, that the MAO and its participating providers pursue through the Internet. The specific requirements that apply depend on the type of communication.

All communications and marketing materials, including contents posted on third-party websites created by participating providers, must be compliant with CMS requirements. Per CMS requirements, 42 C.F.R. §§422.504(i) and 423.505(i), all plans and Part D sponsors must monitor third-party websites that market on their behalf and take appropriate and immediate action if the website is found to be non-compliant.

If participating providers are using websites to market or obtain member information for the purposes of marketing any Medicare part C or part D plans, the plan is held responsible for the content of the website, as well as any activity associated with the use of the inappropriate or misleading information, and will be subject to compliance actions. Non-compliance can include, but is not limited to, the following:

- Inappropriate requests for health status information such as pre-existing conditions, weight, and whether the beneficiary smokes. Federal regulations prohibit discrimination on the basis of medical conditions or medical history and prohibits discriminatory marketing practices to Medicare beneficiaries.
- Misleading information, such as identifying a Medicare Supplement plan as a Medicare plan (links to separate Medicare Supplement pages are allowed).
- Use of prohibited terminology, including unsubstantiated absolute superlatives. such as "Health Net is the best plan we sell." Stating that a plan is "one of the best" is allowed because it is not an absolute superlative.
- Incorrect disclaimers or absence of required disclaimers per Apendix 2 of the MCMG.

Marketing Material Submission

Submission for approval is required if the provider's website or material satisfies one or more of the following criteria:

- The plan name, logo or benefits are mentioned in the material.
- Material explains the benefits of enrollment in any Medicare part C or part D plans, or explains rules that apply to enrollees.
- Material explains how Medicare services are covered under any Medicare part C or part D plans, including conditions that apply to such coverage.
- Material makes no reference to the plan or any other plan sponsor (including plan name, logo or benefits), but material will be used for documenting beneficiary scope of appointment or agreement to be contacted. Materials such as lead cards and business reply cards merit a 45-day CMS review in addition to the plan review.
- Mentions seminars where sale representatives are present.
- Envelopes containing additional information, such as advertising an affiliation, which states more than the required mailing statements that are found in Appendix 2, number 7 of the MCMG. All current member mailings should include one of the following mailing statements:
    - Plan information – "Important plan information"
    - Health and wellness information – "Health and wellness or prevention information"

  Materials referencing Medicare Annual Enrollment Period and timeframe (October 15 to December 7) alone do not require submission, provided no additional information set forth above is included. These materials cannot be disseminated prior to October 1 of each year. Additionally, per Marketing Guidelines Web-based advertisements cannot provide links to a foreign drug site. Submission is not required if material satisfies one or more of the following criteria:

- Material announces a new affiliation other than the plan. Marketing materials for new provider-health plan affiliations do not need to designate that the provider is contracting with other health plans; however, marketing materials for continuing provider-health plan affiliations must continue to clearly state that the provider contracts with other health plans (in accordance with Appendix 2 of the CMS MCMG).
- Material is educational in nature and is free from any plan-specific information, free from bias and does not promote any health plan.

All communications and marketing materials not requiring the plan's review must continue to comply with CMS minimum requirements and are subject to audit. Minimum CMS requirements are as follows:

"Materials should not mislead or confuse beneficiaries by words, symbols, logos or terminology that would imply or give the false impression they are endorsed/approved/authorized by Medicare or any other federal agency or program. In addition, the materials should include accurate terminology and timelines set forth by CMS or any other federal agency referenced."

To help expedite the review process, the plan has created a Provider Medicare Marketing Material Review Checklist (Medicare Advantage (PDF) to ensure CMS requirements are met. The completed checklist along with the marketing material must be submitted to the Medicare Marketing Department by email to start the review and approval process.

Material Review Timelines

Health Net determines the review of the material timelines.

CMS-Accepted Materials

Materials intended to attract or appeal to a potential enrollee, which contain enough detail to entice a potential enrollee to request additional information, may qualify for a CMS-accepted status.

Providers must allow a minimum of 45 calendar days for review of these materials from the date the completed checklist and marketing materials are submitted to the plan. Annual Enrollment Period (AEP) materials qualifying for CMS-accepted status must be submitted to the plan no later than October 15 of each year. AEP materials submitted after October 15 cannot be processed. The 45 calendar-day timeline is based on:

- Materials qualifying for CMS-accepted status
- Three rounds of revisions, which include three business days for each round

45-Day CMS Review of Materials

Providers must allow a minimum of 90 calendar days for review of materials that include explanations of benefits, operational procedures, cost-sharing, or other features of the plan, from the date the completed checklist and marketing material are submitted to the plan. The 90 calendar days provides 45 days for the plan's review and 45 days for CMS review (the plan submits material to CMS on behalf of participating providers). Materials requiring CMS review must be submitted no later than June 1 in order to be reviewed for use during the current CMS contract year.

Multiplan Marketing Materials

The plan should review and approve the material prior to submission to CMS. Per Marketing Guidelines, participating providers may use or distribute the plan or other health plan's marketing materials as long as they make available materials for all plans materials with which the provider participates.

Providers creating marketing materials that mention any Medicare part C or part plans of more than one MAO should select one lead MAO for filing and submission to CMS, ensuring the submission follows:

- CMS Medicare Marketing Guidelines sections 60 and 70 – Activities in Healthcare Setting as well as Websites and Social/Electronic Media
- CMS Medicare Marketing Guidelines in section 90.2.3 – Submission of Multiplan Materials

Providers may select the plan as the lead MAO organization for their submission.

Communicable Diseases Reporting

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

To protect the public from the spread of infectious, contagious and communicable diseases, every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, are required by law to notify the local health department (LHD). A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

The term health care provider includes physicians and surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, and dentists.

Notification

Providers must report cases of communicable diseases using the Confidential Morbidity Report (PDF) . They must send a completed copy of the report to the Communicable Disease Control division of the County Health Department. The time frame for reporting suspected cases of communicable diseases varies according to disease and ranges from immediate reporting by telephone or fax to seven days by mail.

The notification must include the following, if known:

- Name of the disease or condition being reported
- Date of onset
- Date of diagnosis
- Name, address, telephone number, occupation, race or ethnic group, Social Security number (SSN), age, sex, and date of birth for the case or suspected case
- Date of death, if death has occurred
- Name, address and telephone number of the person making the report

HIV Reporting Requirements for Laboratories

The following document applies only to Ancillary providers.

HIV is a reportable disease under California state law. Laboratories are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer for the local jurisdiction where the health care provider is located and the requesting provider within seven calendar days.

Laboratories must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express, registered mail or other traceable mail

- Person-to-person transfer with the local health officer or their designee

Laboratories may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail. Laboratories should contact the local county health department for information and reporting forms.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV
- A component of HIV
- Antibodies to, or antigens of, HIV, including:
  - HIV antibody (HIV-Ab) test
  - HIV p-24 antigen test
  - Western blot (Wb) test
  - Immunofluorescence antibody test

Testing laboratories generate a report that consists of the following information:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Name, address and telephone number of the health care provider and the facility that submitted the biological specimen to the laboratory, if different
- Name, address the telephone number of the laboratory
- Laboratory report number as assigned by the laboratory
- Laboratory results of the test performed
- Date biological specimen was tested in the laboratory
- Laboratory Clinical Laboratory Improvement Amendment (CLIA) number

Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing site, other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

HIV Reporting Requirement for Providers

HIV is a reportable disease under California state law. Health care providers are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer within 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.

Primary Care Physician Responsibilities

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

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

Federal Lobbying Restrictions

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

United States Code Title 31, Section 1352, prohibits the use of federal funds for lobbying purposes in connection with any federal contract, grant, loan, cooperative agreement, or extension, or continuation of any of them. Participating providers are required to develop and comply with filing procedures as follows:

- File a declaration with the plan Net certifying that no inappropriate use of federal funds has occurred or will occur (use Certification for Contracts, Grants, Loans, and Cooperative Agreements Form (PDF)). This extends to any subcontract a participating provider may have that exceeds $100,000 in value. In these cases, the participating provider is required to collect and retain these declarations
- File a specific disclosure form if non-federal funds have been used for lobbying purposes in connection with any line of business (use Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF))
- File quarterly updates, such as a disclosure form at the end of any calendar quarter in which disclosure is required or in which an event occurs that materially affects the previously filed disclosure form

While the statute and related regulations do not specify that the $100,000 limit mentioned in the first bullet is to be calculated annually, the plan believes it reasonable to apply the $100,000 threshold to the term of the Provider Participation Agreement (PPA). If the PPA term is for one year, renewable automatically if not terminated, the threshold would renew at the beginning of each new one-year term. If it is a multiyear term, the calculation of the threshold would be based on the payments received throughout the multiyear term.

Participating providers who complete the Certification for Contracts, Grants, Loans, and Cooperative Agreements Form should send it directly to their assigned provider relations and contracting specialist.

Participating providers are required to comply with applicable state laws and regulations and plan policies and procedures. The contents of the operations manuals are supplemental to the PPA and its addendums. When the contents of the operations manuals conflict with the PPA, the PPA takes precedence.

Health Net Affiliates

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

Below is a listing of Health Net's affiliates. Health Net affiliates generally 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 | Participating Physician Groups (PPG) | Hospitals | 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.

For more information, select any subject below:

- Notice of Nondiscrimination

Notice of Nondiscrimination

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

When the plan makes decisions about employment of staff or provides health care services, it does not discriminate based on a person's race, disability, religion, sex, sexual orientation, ethnicity, creed, age, national origin, or any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Additionally, participating providers must have practice policies that demonstrate that they accept for treatment any member in need of the health care services they provide.

All organizations that provide Medicare managed care, including Health Net Community Solutions, Inc. and its participating providers, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), Section 1557 of the Affordable Care Act of 2010 (ACA), and all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

For additional information regarding eligibility and enrollment criteria, refer to the Enrollment and Eligibility topics.

In accordance with Section 1557 of the Affordable Care Act of 2010 (ACA), the following requirements apply:

- Participating providers must add plan-specific nondiscrimination notices and taglines in significant publications and communications issued to members.
- 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 race, color, national origin, sex, age, or disability. 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.

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
- COB Payment Calculations
- Determination of Primary Insurer
- Medicare Plus (Plan J or HJA)
- Recovery of Excessive Payments
- The Plan's Right to Pay Others
- When the Plan is the Primary Carrier
- When the Plan is the Secondary Carrier

Overview

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

Most group health plans contain a provision stating that, when a member is covered by two or more group health plans, payment is divided between them so that the combined coverage pays up to 100 percent of eligible expenses. This is known as coordination of benefits (COB).

Participating providers are required to apply COB when such provisions are a requirement of the benefit plans.

Members in a Dual Eligibility Special Needs Plan (D-SNP) also have Medi-Cal coverage. Balance billing is prohibited for any D-SNP member.

Medi-Cal is secondary to the plans. When a member is covered under a plan and Medi-Cal, no copayment is to be collected.

Contact Provider Services with any information identifying coverage requiring application of COB for a plan member.

COB allows group health plans to eliminate the opportunity for a person to profit from an illness or injury as the result of duplicate health plan coverage. Generally, one plan is determined by particular rules to be primary, and that plan pays without regard to the other. The secondary plan then makes only a supplemental payment, which results in a total payment of not more than the allowable expenses for the medical service provided.

Under Medicare secondary payor laws, if the plan's member does not have end-stage renal disease (ESRD), is entitled to Medicare based on being age 65 and has other coverage that is sponsored by an employer group plan of 20 or more employees through a current employer or the current employment of a spouse, the other coverage is primary. Similarly, if the member does not have ESRD, but has Medicare based on disability and is covered under other coverage that is sponsored by an employer group plan of 100 or more employees either through a current employer or the current employment of a spouse, other coverage is primary. In cases where the plan pays second to Medicare, the member only receives additional benefits as described in the Schedule of Benefits. The plan is only paid an amount by Medicare to cover such wrap-around benefits. A special rule applies for members who have or develop ESRD, as detailed below.

If any no-fault or liability insurance is available to the member, the benefits under that insurance must be applied to the costs of health care covered by that plan. Where the plan has provided benefits to a member and a judgment is obtained by, or settlement is made with, a no-fault or liability insurer, the member must reimburse the plan. Payment to the plan may be reduced by a share of procurement costs (for example, attorney fees and costs). Workers' compensation for treatment of a work-related illness or injury must also be applied to covered health care costs before benefits under the plan are available.

If a member has, or is diagnosed with, ESRD and is covered under an employer group plan, the member must use the benefits of that plan for the first 30 months after becoming eligible for Medicare based on ESRD. Medicare or the plan is the primary payer after this coordination period.

COB Payment Calculations

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

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

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

Determination of Primary Insurer

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

Medicare Advantage HMO

Determination of the primary insurer for members is based on the laws governing Medicare as a secondary payer, in which the plan assumes the position of Medicare in the order of benefit determination. When a member also has coverage through an employer group plan, the following rules may apply.

Active Employees and Spouses Age 65 or Older

When the subscriber is an active employee or spouse of an active employee age 65 or older, and is covered by an employer group insurance plan and a Medicare plan:

- The employer group plan is primary if the employer has 20 or more employees
- The Medicare plan is primary if the employer has fewer than 20 employees

When a member age 65 or older is an active employee (or spouse) of an employer with 20 or more employees and refuses to accept the health coverage offered by the employer, the plan must pay as primary. The plan may not assert that the active employee be covered by the employer group health plan when the member has decided not to participate in the employer group plan.

In determining the order of payers, the law specifies the threshold of number of employees to be 20 or more. Contact the Medicare Provider Services Department for assistance in determining the number of people employed by an employer-sponsor of the member's health plan.

Retiree Group

When a member age 65 or older is a retiree or a spouse of a retiree, the plan is primary.

Totally Disabled

When an actively employed group member under age 65 (most often a spouse or child) is disabled and does not have end-stage renal disease (ESRD), and total disability is the sole basis for Medicare coverage, and has an employer group plan and a plan:

- The employer group plan is primary if the employer has 100 or more employees.
- The plan is primary if the employer has fewer than 100 employees.

In determining the order of payers, the law specifies that a group is affected when the employer normally employs at least 100 employees on a typical business day during the previous calendar year. Contact the

Medicare Provider Services Department for assistance in determining the number employed by an employer-sponsor of the member's health plan.

End-Stage Renal Disease

When an employer group member (most often a spouse or child) belongs to either an active or retiree plan through an employer group plan and ESRD is the sole basis for Medicare coverage (for example, the member is not age 65 or over or totally disabled), the employer group plan is primary for the first 30 months of Medicare eligibility. This rule applies regardless of whether the group coverage is provided through active employment or retirement, and regardless of the number of employees of the employer who sponsors the group plan. Original Medicare or the Medicare Replacement plan is primary after the first 30 months of Medicare eligibility.

Only the Medicare contractor for the participating provider's geographic area can determine the date on which Medicare becomes primary for ESRD Medicare beneficiaries. For each case, contact the Medicare contractor to determine the date that Medicare is primary.

Medicare Plus (Plan J or HJA)

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

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

- Medicare is primary
- The plan is always secondary

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

Medicare Plus is available to subscribers and their spouses when:

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

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

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

Recovery of Excessive Payments

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

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

The Plan's Right to Pay Others

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

A payment made by another health plan may include an amount that should have been paid by the plan. If this happens, the plan may pay the amount to the organization that made the payment. The amount is then treated as though paid under the member's coverage. The plan does not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

When the Plan is the Primary Carrier

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

When the plan is the primary carrier, the participating provider is entitled to bill the other carrier as secondary after the provider has received the plan's adjudication decision.

A member is not entitled to an itemized statement reflecting the cash value of the services provided by the participating provider and covered by the plan (compliance with a request for itemization could enable a member to obtain unjust payment from an insurer or to document an itemized tax deduction far in excess of the actual cost).

A member is entitled to a statement documenting copayments made to the participating provider and charges for services not covered by the plan.

When Wellcare By Health Net is the primary payer and the member is enrolled in our exclusively aligned Dual Special Needs Plan (D-SNP), the secondary claim will be automatically forwarded to Health Net for payment on the Medi-Cal covered portion.

Refer to Claims Reimbursement and Balance Billing sections for more information.

When the Plan is the Secondary Carrier

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

When the plan is the secondary carrier, the participating provider is entitled to receive payment from the primary carrier for services provided directly to the member.

The participating provider should obtain the signature of the member who is the policyholder with the other carrier on a standard Assignment of Benefits form.

The participating provider should also obtain from the member any claim form the other carrier might require.

Upon receiving an adjudication decision from the primary carrier, the participating provider submits a secondary claim to the plan with an attachment of the primary carrier's Explanation of Benefits (EOB). When the participating provider expects to receive reimbursement from the plan amounting to more than any required copayment, do not collect a copayment.

If, after both carriers have reimbursed the participating provider, the provider has not received reimbursement equal to or greater than the amount that is due under the provider's Provider Participation Agreement (PPA), the member can be billed for the required copayment provided the total reimbursement from all sources is no greater than what is due under the provider's PPA.

When the primary carrier is another HMO and the member is enrolled with two different participating providers (one with the primary carrier and one with the plan), the member may receive services through either participating provider. The participating provider cannot deny services based on the plan's status as the secondary carrier.

Copayments

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

This section includes general information on the collection and verification of copayments.

Select any subject below:

- Collection of Copayments for Referrals
- Collection of Medicare Copayments
- Out-of-Pocket Maximum
- Verify Copayments

Collection of Copayments for Referrals

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

Outside referrals include:

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

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

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

Collection of Medicare Copayments

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

A member copayment is a set dollar amount based on the service provided, unlike coinsurance that is a percentage of the total cost of a service. Member copayments are determined by the plan. Providers may collect member copayments when a member is treated by a physician, physician assistant, nurse practitioner, or any qualified professional provider for basic medical care. The provider type does not dictate the copayment amount.

Member copayments should be collected at the time the service is provided. If immediate collection of a copayment is not possible, the provider may bill the member for the copayment amount only. Providers may not impose a surcharge on a member for covered services provided or collect copayments or any other fees for missed appointments. Providers have the option of having the member transferred after three missed appointments.

Most plans require a member copayment for covered services or supplies. Member copayment amounts vary by plan, county and type of service. A service rendered by any provider type other than the member's assigned PCP may be subject to a separate and different copayment amount. For example, the copayment amount for a primary care physician (PCP) office visit may vary from the copayment amount of a specialist office visit. Copayment amounts can be collected for most services including PCP office visits, specialist office visits (with exception to preventive care services under some plans), emergency room services, urgent care center visits, inpatient hospitalization, outpatient surgery, and prescription medications.

Some member identification (ID) cards list only the PCP office visit copayment. For example, a member may incur a $15 copayment for a PCP office visit and a $25 copayment for a specialist office visit (or consultation) depending on the plan.

Members are not subject to copayments if they have full dual-eligibility with Medicare Advantage and Medi-Cal, Medi-Cal managed care.

To ensure accurate collection of copayments, providers should refer to the member's Evidence of Coverage (EOC) or the plan's Schedule of Benefits and Summary of Benefits for specific services and applicable copayment amounts. The Schedule of Benefits is available on the provider website.

Out-of-Pocket Maximum

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

The Centers for Medicare and Medicaid Services (CMS) mandates that health plans include an out-of-pocket maximum (OOPM) on Medicare Advantage (MA) plans. The OOPM benefit mandate affects capitated participating physician groups (PPGs), dual-risk hospitals and capitated ancillary providers, and applies to all Part A and Part B medical covered services, including behavioral health and substance abuse services. The OOPM does not apply to supplemental benefits and Part D prescription medication benefits.

In order to meet this regulatory requirement, the plan's capitated medical groups, facilities and ancillary providers must include member-paid copayment amounts on all professional and institutional Medicare claims and encounter data. In addition, any rejected Medicare encounter data must be corrected and resubmitted in order for correct member-paid copayment amounts to be captured and accumulated.

Verify Copayments

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

Most Medicare Advantage (MA) plans require a member copayment for covered services or supplies. Member copayment amounts vary by plan, county and type of service.

To ensure accurate collection of copayments, providers should refer to the member's Evidence of Coverage (EOC) or the Schedule of Benefits or Summary of Benefits for specific services and applicable copayment amounts. The Schedule of Benefits is available on the provider portal website.

Credentialing

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

This section describes Health Net's provider credentialing process.

Select any subject below:

- Application Process

Application Process

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

Practitioners or organizational providers subject to credentialing or recredentialing and contracting directly with the plan must submit a completed plan-approved application. By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes the plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review.
- Releases the plan and its independent contractors, agents and employees from any liability connected with the credentialing review.

Approval, Denial or Termination of Credentialing Status

The Credentialing Committee or physician designee reviews rosters of delegated and non-delegated practitioners and organizational providers meeting all plan criteria and approves their admittance or continued participation in the network.

A peer review process is used for practitioners with a history of adverse actions, member complaints, negative quality improvement (QI) activities, impaired health, substance abuse, health care fraud and abuse, criminal history, or similar conditions to determine whether a practitioner should be admitted or retained as a participant in the network.

Practitioners are notified within 60 calendar days of all decisions regarding approval, denial, limitation, suspension, or termination of credentialing status consistent with the health plan, state and federal regulatory requirements and accrediting entity standards. This notice includes information regarding the reason for denial determination. If the denial or termination is based on health status, quality of care or disciplinary action, the practitioner is afforded applicable appeal rights. Practitioners who have been administratively denied are eligible to reapply for network participation as soon as the administrative matter is resolved.

Failure to respond to recredentialing requests may result in the practitioner's administrative termination from the network.

Appeals

Practitioners, whose participation in the plan's network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons, are provided notice and an opportunity to appeal. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from, the network.

The notice of altered participation status will be provided in writing to the affected practitioner and include:

- The action proposed against the practitioner by the Credentialing or Peer Review committee.
- The reason for the action.
- The plan policies or guidelines that led to the committee's adverse determination.
- Detailed instructions on how to file an appeal (informal reconsideration or formal hearing).

A practitioner may choose to engage in an informal appeal and provide additional information for the Credentialing Committee's consideration or move directly to a formal fair hearing. Affected practitioners who are not successful in overturning the original committee decision during an informal reconsideration are automatically afforded a fair hearing, upon request in writing within 30 days from the date of notice of the denial.

A practitioner must request a reconsideration or fair hearing in writing. The plan's response to the request will include:

- Dates, times and location of the reconsideration or hearing.
- Rules that govern the applicable proceedings.
- A list of practitioners and specialties of the committee or fair hearing panel.

The composition of the fair hearing panel must include a majority of individuals who are peers of the affected practitioner. A peer is an appropriately trained and licensed physician in a practice similar to that of the affected practitioner.

Affected practitioners whose original determinations are overturned are granted admittance or continued participation in the plan's network. The decision is forwarded to the affected practitioner in writing within 14 calendar days of the fair hearing panel's decision.

Affected practitioners whose original determinations have been upheld are given formal notice of this decision within 14 days of the fair hearing panel's ruling. The actions are reported to the applicable state licensing board and to the National Practitioner Data Bank (NPDB) within 14 days of the hearing panel's final decision.

Practitioners who have been denied or terminated for quality-of-care concerns must wait a minimum of five years from the date the adverse decision is final in order to reapply for network participation. At the time of the reapplication, the practitioner must:

- Meet all applicable plan requirements and standards for network participation.
- Submit, at the request of the committee or Credentialing Department, additional information that may be required to confirm the earlier adverse action no longer exists.
- Fulfill, according to applicable current credentialing policies and procedures, all administrative credentialing requirements of the plan's credentialing program.

Credentialing Responsibility, Oversight and Delegation

The plan may delegate to individual practitioners, participating physician groups (PPGs) or other entities responsibility for credentialing and recredentialing activities. Credentialing procedures used by these entities may vary from plan procedures, but must be consistent with the health plan, state and federal regulatory requirements and accrediting entity standards.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the oversight of delegated activities must meet or exceed plan standards. The plan oversees delegated responsibilities on an ongoing basis through an annual audit and semiannual, or more frequent, review of delegated PPG-specific data.

The plan can revoke the delegation of any or all credentialing activities if the delegated PPG or entity is deemed noncompliant with established credentialing standards. The plan retains the right, based on quality issues, to terminate or restrict the practice of individual practitioners, providers and sites, regardless of the credentialing delegation status of the PPG.

Each delegated practitioner or provider losing delegated credentialing status must complete the plan's initial credentialing process within six months.

Hiring Non-Participating Providers

The following document applies only to Physicians and Participating Physician Groups (PPG).

In an effort to comply with applicable federal and state laws and regulations, all participating providers in the plan's network must comply with the following standards when hiring a non-participating provider to provide services to plan members. Participating providers must be able to demonstrate that each non-participating provider has supporting documentation that includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable.
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Malpractice insurance coverage that meet these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- Absent of any sanctions that would not allow them to see a Medicare member.

Additionally, the practitioner must be absent from:

- The Medicare Opt Out report if treating Medicare members.
- The Office of the Inspector General's (OIG) sanctions list of individuals and entities (LEIE) if treating Medicaid and Medicare members.
- The System for Award Management's Exclusions Extract Data Package (EEDP) if treating Medicare members.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.

The plan's participating providers are responsible for ongoing monitoring of sanctions and validating licensing. All participating providers are required to comply with applicable federal, state and local laws and regulations as well as the policies and procedures as outlined in the Provider Participation Agreement (PPA).

Investigations

The plan investigates adverse activities indicated in a practitioner or provider's initial credentialing or recredentialing application materials or identified between credentialing cycles. The plan may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. Health Net may require a practitioner or provider to supply additional information regarding any such adverse activities. Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board.
- Current or past chemical dependency or substance abuse.
- Health care fraud or abuse.
- Member complaints.
- Substantiated quality of care concerns activities.
- Impaired health.
- Criminal history.
- Office of Inspector General (OIG) Medicare/Medicaid sanctions.
- Federal Employees Health Benefits Program (FEHBP) debarment.
- System Award Management (SAM), inclusive of Excluded Parties List System (EPLS), EEDP.
- The Medi-Cal Suspended and Ineligible Provider listing.
- Substantiated media events.
- Trended data.

At the plan's request, a practitioner or provider must assist the plan in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within the prescribed time frames.

Organizational Providers Certification or Recertification

An organizational provider (OP) is an institutional provider of health care that is licensed by the state or otherwise authorized to operate as a health care facility. Examples of OPs include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and ambulatory surgical centers (ASCs).

Organizational providers that require assessments by the plan or its delegated entities include:

- Hospitals

- Home health agencies
- Hospices
- Clinical laboratories *(accreditation is mandatory)*
- Skilled nursing facilities
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy, occupational therapy and speech pathology providers
- Ambulatory psychiatric and addiction disorder facilities and clinics
- Psychiatric and addiction disorder residential treatment facilities
- Twenty-four-hour behavioral healthcare units in general hospitals
- Substance abuse treatment facilities
- Other freestanding psychiatric hospitals and treatment facilities
- Ambulatory surgery centers
- Providers of end stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable x-ray suppliers

- Rural health centers (RHCs), federally qualified health centers (FQHCs) and Indian Health Centers (IHCs)*
- Sleep study centers (as applicable)
- Radiology/imaging centers (as applicable)
- Urgent care facilities (as applicable)
- Community Based Adult Services (CBAS)
- Free Standing and Alternative Birthing Centers
- Telehealth/Telemedicine Services Provider*
- Intermediate Care Facility

CalAIM - Community Supports Provider/In Lieu of Services Provider.**

Non-Traditional providers are not certified or credentialed. They require vetting to ensure acceptance into our network. Of note; if a traditional Provider, Hospital, Ancillary, PPG or Practitioner oversee the non-traditional providers, the Provider is responsible to ensure they meet the needs to join our network.

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Community Transition Services/Nursing
- Facility Transition to a Home
- Personal Care and Homemaker Services
- Sobering Centers
- Environmental Accessibility Adaptions (Home Modifications)
- Meals/Medically Tailored Meals or Medically Supportive Foods
- Asthma Remediation
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF)

CalAIM – Enhanced Care Management Provider**

Community Health Worker - Provider**

*The facility is exempt from the certification process if the individual practitioners within this clinic are individually contracted/credentialed.

** Non-Traditional Care Facilities are required to submit a vetting attestation only.

Is licensed to operate in the state and is following any other applicable federal or state requirements.

Providers contracting directly with the plan must submit a completed, signed plan-approved hospital or ancillary facility credentialing application and any supporting documentation to the plan for processing. The documentation, at a minimum, includes:

- Evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an on-site survey prior to being issued a state license. Accepted agency surveys include those performed by the state Department of Health and Human Services (DHHS), Department of Public Health (DPH) or Centers for Medicare & Medicaid Services (CMS).

- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess a current city license, fictitious name permit, certificate of need, or business registration.
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent DHHS/DPH site survey as described above is required. A favorable site review consists of compliance with quality-of-care standards established by CMS or the applicable state health department. The plan obtains a copy of each surgery center's site survey report and ensures each provider has received a favorable rating. This may include a completed corrective action plan (CAP) and DHHS CAP acceptance letter.
- Professional and general liability insurance coverage that meets plan requirements.
- Overview of the facility's quality assurance/quality improvement program upon request.

Organizational providers are recredentialed at least every 36 months to ensure each entity has continued to maintain prescribed eligibility requirements.

Practitioner's Rights

Right of Review Request for Current Network Status

A practitioner has the right to review information obtained by the plan for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (for example, malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to the credentialing manager or supervisor. The credentialing manager or supervisor notifies the practitioner within 72 hours of the date and time when such information is available for review at the Credentialing Department. Upon written request, the Credentialing Department provides details of the practitioner's current status in the initial credentialing or recredentialing process.

Notification of Discrepancy

Practitioners are notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board-certification expiration when one or more of these examples have not been self-reported by the practitioner on their application. Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

A practitioner who believes that erroneous information has been supplied to the plan by primary sources may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed explanation, to the Credentialing Department manager or supervisor. Notification to the plan must occur within 48 hours of the plan's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of their credentials file. Upon receipt of notification from the practitioner, the plan re-verifies the primary source information in dispute. If the primary source information has changed, a correction is made immediately to the practitioner's credentials file. The

practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to the Credentialing Department via letter or fax within 10 business days. The Credentialing Department re-verifies primary source information if such documentation is provided. If after 10 business days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.

Primary Source Verification for Credentialing and Recredentialing

The Credentialing Department obtains and reviews information on a credentialing or re-credentialing application and verifies the information in accordance with the primary source verification practices. The plan requires participating physician groups (PPGs) to which credentialing has been delegated to obtain primary source information (outlined below)* in accordance with the standards of participation, state and federal regulatory requirements, and accrediting entity standards.

*Primary Source Verification

- Medical doctors (MD)
- Nurse Practitioners (NP)
- Oral surgeons (DDS/DMD)
- Chiropractors (DC)
- Osteopaths (DO)
- Podiatrists (DPM)
- Mid-level practitioners (non-physicians)
- Acupuncturist

Recredentialing for Practitioners

The plan's credentialing program establishes criteria for evaluating continuing participating practitioners. This evaluation, which includes applicable primary source verifications, is conducted in accordance with the health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners meeting and maintaining the standards for participation requirements are retained in the network.

Practitioners due for recredentialing must complete all items on an approved plan application and supply supporting documentation, if required. Documentation includes, but is not limited to:

- Current state medical license.
- Attestation to the ability to provide care to members without restriction.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate or Chemical Dependency Services (CDS) certificate, if applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state.

- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one participating hospital or surgery center, or a documented coverage arrangement with a credentialed or participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- Trended assessment of practitioner's member complaints, quality of care, and performance indicators.

Standards of Participation

All practitioners participating in the plan's network must comply with the following standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing and practitioners due for recredentialing must complete all items on an approved credentialing application and supply supporting documentation, if required. The verification time limit for a plan approved application is 180 days. Applications are available at the Council of Affordable Quality Healthcare (CAQH) website at www.caqh.org for the Universal Credentialing DataSource link. Supporting documentation includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable. The DEA and/or CDS registration must be issued in the state(s) in which the practitioner is contracting to provide care to the members.
- Continuous work history for the previous five years with a written explanation of any gaps of a prescribed time frame (initial credentialing only).
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Evidence of active admitting privileges in good standing, with no reduction, limitation, or restriction on privileges, with at least one participating hospital or surgery center, contracted hospitalist group or a documented coverage arrangement with a credentialed, participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely.

Additionally, the practitioner must be absent from:

- The Medicare Opt-Out Report if treating members under the Medicare lines of business.
- The Medicare/Medicaid Cumulative Sanction Report if treating members under the Medicare lines of business.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.
- The Excluded Parties List System (EPLS) EEDP through the System for Award Management (SAM) Report.
- The Medi-Cal Suspended and Ineligible Provider listing.

Terminated Contracts and Reassignment of Members

The plan notifies members as required by state law if a practitioner's contract participation status is terminated. The plan oversees reassignment of these members to another participating provider where appropriate.

Denial Notification

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

This section contains general information for claims and service denials.

Select any subject below:

- Claims Denial Requirements
- Denial of Investigational or Experimental Treatment for a Terminal Illness
- Service Denial Templates
- Integrated Denial Notification - Notice of Denial Medical Coverage Template Information
- Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage (Ancillary)
- Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage (PPGs)
- Notification Delays
- Requirements for Notification of Utilization Management Decisions

Claims Denial Requirements

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

Delegated participating providers and capitated hospitals are required to notify the provider when a claim is denied. The denial notice must contain the following elements:

- Date of denial notice
- Member name
- Provider name
- Specific service denied
- Date of service
- Denied amount
- Member responsibility amount
- Information regarding the providers' appeal rights with Health Net. Include plan name, address and telephone number for appeals.

The Centers for Medicare & Medicaid Services (CMS)-approved Integrated Denial Notice - Notice of Denial of Payment (IDN-NDP) letters must be sent to members when the claim denial results in any member financial liability. The IDN-NDP letter includes the denial notice page, accompanying member appeals language and Notice of Non-Discrimination and multi-language insert.

For DSNP members in Exclusively Aligned Enrollment (EAE) counties, PPGs must use the Applicable Integrated Plan (AIP) Coverage Decision Letter.

For both the denial notice and appeals page, it is not permissible to omit any standardized language, nor alter the template, including font size, without CMS approval. Minor changes to the denial notice page that do not affect the intent of the document may be allowed upon approval from the Medicare Compliance Department.

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

Denial letters to members must not indicate that Health Net or another group is responsible for the claim.

Information required in the space reserved for the explanation of a denial must specify the reasons for the denial, as required under 42 CFR 422.568 (e)(2). For Medicare Advantage providers, the CMS-approved Industry Collaboration Effort (ICE) standardized Single Service Claim Denial Letter and Multiple Services Claim Denial Letter are located under Approved ICE Documents on the ICE website at www.iceforhealth.org/library.asp . Additional information is available on the CMS website at www.cms.gov or from the ICE website at www.iceforhealth.org .

Compliance with Claim Denial Letter Requirements

Health Net conducts ongoing review of delegated participating provider compliance with Medicare claim denial letter requirements.

Denial of Investigational or Experimental Treatment for a Terminal Illness

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

In accordance with Centers for Medicare & Medicaid Services (CMS) guidelines, providers must follow the process for review of investigational or experimental treatment for a terminal illness. Health Net is required to review all requests for these procedures and, in the case of a denial, is responsible for issuing the denial letter. Refer to the Health Industry Collaboration Effort (ICE) website at www.iceforhealth.org/home.asp to view the denial letter template located under Approved ICE documents.

Participating physician groups (PPGs) are required to notify Health Net immediately of member requests or proposed services for expedited investigational or experimental treatment for a terminal illness.

Definition of a Terminal Illness

A terminal illness is defined as an incurable or irreversible condition that has a high probability of causing death within two years.

Definition of an Expedited Request

An expedited request is defined as a time-sensitive situation where a delay in treatment or an adverse decision could seriously jeopardize the life or health of the member or their ability to regain maximum function. This includes severe pain or potential loss of life, limb or major bodily function.

PPG Responsibilities

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

Health Net follows the denial letter process and Health Net's Continuity and Coordination of Care Department has a dedicated fax number and address to receive PPGs' submissions of these cases to ensure timely processing.

Service Denial Templates

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

In accordance with standards established by CMS, Medicare Advantage Organizations (MAOs), delegated participating providers and hospitals are required to issue service denial letters. CMS has specific service denial letter templates that delegated participating providers and hospitals are required to issue to a member when certain services are denied.

Refer to the ICE website at www.iceforhealth.org/library.asp to access the ICE/CMS approved service denial templates listed below:

- Integrated Denial Notification - Notice of Denial of Medical Coverage (IDN-NDMC) with instructions
- Detailed Notice of Discharge (DND)
- Detailed Explanation of Non-Coverage (DENC) with instructions
- Notice of Medicare Non-Coverage (NOMNC) with instructions
- Integrated Denial Notification - Notice of Denial of Payment (IDN-NDP)

Integrated Denial Notification - Notice of Denial Medical Coverage Template Information

Provider Type: Participating Physician Groups (PPG)

All Medicare Advantage Organizations (MAOs), including providers and delegated participating physician groups (PPGs) must issue the Integrated Denial Notice (IDN) - Notice of Denial of Medical Coverage (NDMC) letter to members when the delegated PPG denies in whole or in part, a request for a medical service/item. This may include cases when the delegated PPG denies a medical service requested by the member. A decision must be made as expeditiously as the member's health condition requires. Refer to the Centers for Medicare & Medicaid (CMS) website at www.cms.gov for downloading CMS-approved templates.

Applicable Integrated Plan (AIP) coverage decision letter for DSNP members in Exclusively Aligned Enrollment (EAE) counties

The Applicable Integrated Plan (AIP) Coverage Decision Letter is used instead of the Integrated Denial Notification form for the DSNP members in EAE counties. The AIP Coverage Decision Letter is available in Delegation Oversight Interactive Tool (DOIT) for PPGs to access.

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.

Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage

Provider Type: Ancillary

The Notice of Medicare Non-Coverage (NOMNC) is a written notice designed to inform Medicare members that their covered skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) care is ending. The Detailed Explanation of Non-Coverage (DENC) is a standardized written notice that provides specific and detailed information to Medicare members of why their covered SNF, HHA, or CORF services are ending.

To ensure that all service determinations are appropriate and consistent with Centers for Medicare & Medicaid Services (CMS) requirements, delegated providers and their subcontracting medical providers must work together to issue NOMNC letters to members who are being discharged from a SNF, HHA or CORF when services are ending. It is the SNF, HHA or CORF's responsibility to physically deliver the notice to the member within the required time frames.

The provider that delivers the NOMNC notice must list its contact information in the header section of the NOMNC. For example, if staff at the SNF delivers the notice, the SNF's contact information must be listed. The entire notice must fit on two pages. There are no additional pages to this document.

The provider that delivers the DENC must also list its contact information in the header section of the DENC. The name, address and toll-free number of the provider or plan that actually delivers the notice must appear above the title of the form. The entity's registered logo is not required, but may be used. If providers do not have their own toll-free numbers, they must insert their contact information, along with Health Net's Customer Contact Center that is located on the back of the member's identification (ID) card.

Medicare Advantage (MA) providers may download the CMS-approved templates from the ICE website at www.iceforhealth.org Providers may also download the forms from the CMS website at www.cms.gov.

Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage

Provider Type: Participating Physician Groups (PPG)

The Notice of Medicare Non-Coverage (NOMNC) is a written notice designed to inform Medicare members that their covered skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) care is ending. The Detailed Explanation of Non-Coverage (DENC) is a standardized written notice that provides specific and detailed information to Medicare members of why their covered SNF, HHA or CORF services are ending.

To ensure that all service determinations are appropriate and consistent with Centers for Medicare & Medicaid Services (CMS) requirements, delegated participating physician groups (PPGs) and their subcontracting medical providers must work together to issue NOMNC letters to members who are being discharged from a SNF, HHA or CORF when services are ending. It is the SNF, HHA or CORF's responsibility to physically deliver the notice to the member within the required time frames.

The provider that delivers the NOMNC notice must list its contact information in the header section of the NOMNC. For example, if staff at the SNF delivers the notice, the SNF's contact information must be listed. The entire notice must fit on two pages. There are no additional pages to this document.

The provider that delivers the DENC must also list its contact information in the header section of the DENC. The name, address and toll-free number of the provider or plan that actually delivers the notice must appear above the title of the form. The entity's registered logo is not required, but may be used. If providers do not have their own toll-free numbers, they must insert their contact information, along with Health Net's Customer Contact Center that is located on the back of the member's identification (ID) card, above the title of the form.

The CMS-approved template can be downloaded from the ICE website at www.iceforhealth.org. For additional information, refer to CMS website at www.cms.gov.

Quality Improvement Organization Appeals

Members or the member's authorized representative have the right to appeal the decision to terminate services from a SNF, HHA or CORF to the Quality Improvement Organization (QIO) appeals. If an appeal is requested by the member or member's authorized representative, the delegated PPG or Health Net must issue a DENC to the member as well as provide all requested medical records, as required by the QIO, as soon as possible, but no later than 4:30 p.m. on the day the QIO notifies Health Net.

The QIO, which operates 365 days a year, notifies Health Net upon making a determination. A representative from Health Net contacts the hospital or the SNF, HHA or CORF and PPG case manager to inform him or her of the appeal determination, including on weekends and holidays.

In addition, if the QIO reverses any determination decision to terminate SNF, HHA or CORF services, the delegated PPG or their subcontracting medical providers must provide the member with a new NOMNC, consistent with CMS regulation 42 C.F.R. Section 422.626(e).

Dual-Risk PPG Responsibilities

Health Net notifies the delegated PPG of the appeal request. All required CMS notices and records must be provided to the member and the QIO in accordance with the appeal request within the required CMS timelines. If Health Net requests a copy of the signed NOMNC or DENC, it must be sent to Health Net within five business days.

Shared-Risk PPG Responsibilities

When Health Net notifies the delegated PPG of the appeal, the delegated PPG must then prepare and provide to Health Net a completed DENC using the CMS-approved Health Net DENC template within two hours of notification of the appeal request if the appeal is received prior to 1:00 p.m. If the appeal is received after 1:00 p.m., the DENC is due to Health Net by 3:00 p.m. in order for the DENC to be delivered to the member by 4:30

p.m. to meet timeliness standards. Delegated PPGs must also provide a copy of the signed NOMNC to Health Net at the time of delivery of the DENC to Health Net.

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.

Requirements for Notification of Utilization Management Decisions

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net and its participating physician groups (PPGs) to which utilization management (UM) functions have been delegated are required to comply with standards established by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

In accordance with CMS guidelines and federal regulations 42 CFR Section 422.620(d), prior to discharging a Medicare Advantage (MA) member from an inpatient level of care, the MA organization, and its delegated PPGs must obtain concurrence from the treating physician who is responsible for the member's inpatient care.

Inpatient facility authorizations must be based on the treating physician's orders and plan of care. MA inpatient denials cannot be issued by PPGs or Health Net unless there is concurrence from the Health Net MA member's treating physician. However, the inpatient hospitalization episode of care, as directed by the treating physician, is subject to post-claim payment review and recoupment, if deemed appropriate based on CMS criteria,

including federal laws, rules, regulations, and CMS manual guidelines. Health Net is engaging a vendor to perform such post-claim payment review, which may involve requests to PPGs for medical records in order to determine appropriate actions based on CMS criteria for medical necessity.

Health Net oversees, and is ultimately responsible to CMS for, any functions and responsibilities described in MA regulations. In accordance with federal regulation 42 CFR Section 422.504 (i)(4)(v), Health Net and its delegated PPGs must comply with all applicable Medicare laws, regulations and CMS instructions.

Disenrollment

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

This section contains general information and procedures regarding member disenrollment requirements.

Involuntary Disenrollment

Health Net does not, either verbally or in writing or by any action or inaction, request or encourage a Medicare member to disenroll. However Health Net must disenroll a member from a Medicare Advantage plan due to death, failure to pay the Part D-Income Related Monthly Adjustment Amount (IRMAA), a move outside of the plan's service area, including incarceration, loss of Medicare Part A or Part B, loss of special needs status (if the member is enrolled in a Special Needs Plan (SNP)), or a non-renewal or service area reduction. Health Net may disenroll a member if the member engages in disruptive behavior, provides fraudulent information on an enrollment request or if the member permits abuse of an identification card (ID).

Health Net has the right to disenroll a Health Net Medicare Advantage (MA) member under the following circumstances, for instance:

- When a member fails to pay Part D-IRMAA. Centers for Medicare & Medicaid Services (CMS) will report the disenrollment to Health Net if the member fails to pay the Part-D IRMAA within a 3-month grace period.
- When Health Net confirms that the member has permanently moved outside the plan's service area, Health Net must disenroll the member. Health Net is required to send a written notice informing the member of its intent to disenroll and explain the member's right to file a grievance against this action.
- When a member is temporarily outside the Health Net MA plan service area for a period of six months or longer, Health Net is required to disenroll the member. Only emergency services, out-of-area urgent care, and out-of-area renal dialysis are covered while the member is temporarily out of the plan's service area.
- Disruptive behavior by a member, which is so disruptive, unruly, abusive, or uncooperative to the extent that continuing membership seriously impairs Health Net or its participating providers' ability to provide services to the member or other members. Disruptive behavior includes threats of violence by the member to employees of Health Net or its participating providers. Health Net disenrolls members for disruptive behavior only after serious efforts to resolve the problem, including the use of internal grievance procedures, consideration of extenuating circumstances, and the Centers for Medicare & Medicaid Services' (CMS') advance approval of the proposed

disenrollment, have been made. Disenrollment is effective the first day of the calendar month after the month in which final notice is sent to the member of the intended action.

Member Disenrollment Procedure

A member may disenroll by:

- Enrolling in another plan (during a valid enrollment period).
- Giving or faxing assigned written notice to Health Net or through their employer or union.
- Calling 1-800-633-4227 (1-800-MEDICARE).

The election period during which Health Net receives a valid request to disenroll will determine the member's effective date of disenrollment. After the member submits a request, Health Net must provide the member with a disenrollment notice within ten calendar days of the request to disenroll. The notice will provide the effective date of disenrollment. If Health Net receives a disenrollment request that must be denied, the member will be notified within ten calendar days of the receipt of the request. The notice will include the reason for the denial. Health Net continues to be responsible for the member's health care until disenrollment is approved by Centers for Medicare and & Medicaid Services (CMS).

Provider Request to Disenroll a Member

To request disenrollment of a Medicare member, providers may contact the Medicare Programs Provider Services Department. Providers are asked to describe the circumstances leading them to request the disenrollment and may be asked to submit documentation regarding their requests. If necessary, Health Net reassigns the member to a new primary care physician (PCP) within the plan. If reassignment is not possible and the member requires disenrollment based on the guidelines outlined below, then Health Net sends the information to Centers for Medicare & Medicaid Services (CMS) for approval or disapproval of the disenrollment request. Health Net cannot terminate Medicare members without CMS approval. Once the disenrollment has been approved, a letter is sent to the member.

A provider-initiated disenrollment request based on the breakdown of the provider-member relationship is considered good cause and is approved by CMS 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.
- The member has allowed fraudulent use of the Health Net identification card to receive services from Health Net providers.

Failure to follow prescribed treatment, including failure to keep appointments, is not, in itself, good cause for disenrollment.

Disenrollment for Disruptive Behavior

Health Net may request to disenroll a member if their behavior is disruptive to the extent that they continued enrollment in the Medicare Advantage (MA) plan substantially impairs Health Net's ability to arrange for or provide services to either that particular member or other members of the plan. However, Health Net may

disenroll a member for disruptive behavior only after Health Net has met the requirements outlined in chapter 2 of the Medicare Managed Care Manual, Section 50.3.2 and obtained CMS approval.

Before requesting CMS approval of disenrollment for disruptive behavior, Health Net must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. Health Net must also inform the individual of their right to use Health Net's grievance procedures.

Retroactive Disenrollment by CMS

The Centers for Medicare & Medicaid Services (CMS) can approve retroactive disenrollment in the following instances:

- System problems with CMS, the Social Security Administration (SSA) or Health Net Medicare Advantage (MA)
- SSA errors in processing disenrollment requests made by Health Net MA plan members at the SSA district office
- Beneficiary did not intend to enroll in a Health Net MA plan
- Death of a member
- Requests for disenrollment relating to marketing misrepresentations

A written request for retroactive disenrollment must be submitted to the Health Net Medicare Programs Member Services Department by the member. Depending on the circumstances, CMS may approve a partial disenrollment.

Disenrollment of Employer Group Members

When a Health Net Medicare Advantage (MA) plan member disenrolls through an employer group, there may be a delay in processing the disenrollment request. In these cases, the CMS allows a retroactive disenrollment not to exceed 90 days.

Voluntary Disenrollment

A member may only disenroll from a plan during one of the specified election periods. The member must submit a written request to the Member Services Department or through his or her employer. The written request must be signed by the member or member representative before the disenrollment date. The member may choose an effective date of up to three months after the month in which the individual completed a disenrollment request; however the effective date of disenrollment may not be earlier than the first of the month following the month in which the request was made.

When a member enrolls in another MA plan, the member is automatically disenrolled from Health Net's MA plan at the time the membership in the new MA plan becomes effective. In these situations, the member should not submit a written request for disenrollment to his or her health plan.

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:

- Expedited Reviews
- Member Appeals
- Provider Appeals and Dispute Resolution
- Grievances

Expedited Reviews

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

This section includes information on expedited organization determinations and expedited member appeal reviews.

Select any subject below:

- Expedited Reviews Overview
- Expedited Organization Determination Rules
- Expedited Organization Determination Criteria and Process

Expedited Reviews Overview

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

The Centers for Medicare and Medicaid Services (CMS) requires that Medicare Advantage Organizations (MAOs) and participating providers promptly address all member concerns and complaints that are brought to their attention either orally or in writing. CMS also requires that MAOs have a process in place for expedited reviews of time-sensitive issues. Time-sensitive issues are defined as:

- Situations where waiting 7 to 14 days for an initial determination, or 30 days for a service reconsideration, could seriously jeopardize the life and health of the member or the member's ability to regain maximum function

All requests for service must be promptly reviewed to determine whether the request meets the established criteria. Requests for services that meet established criteria must be reviewed and resolved with 72 hours of receipt. The 72-hour time frame includes weekends and holidays and begins upon receipt, even if additional information is needed.

There are two types of expedited reviews:

- Expedited organization determination (EOD)
  - An EOD is a decision to authorize or deny a time-sensitive service that meets the criteria for an expedited review.
  - This type of expedited review is delegated to participating physician groups (PPGs) and monthly tracking logs are required. The plan does not delegate this responsibility to direct network physicians. Refer to the Expedited Organization Determination Process discussion for additional information.
- Expedited appeal
  - An expedited appeal is a time-sensitive service appeal that meets the criteria for an expedited review.
  - This type is not delegated to participating providers. Refer to the Expedited Appeals Process discussion below for additional information.

Criteria for Expedited Review

Requests that meet the criteria for an expedited review are:

- Requests by a participating provider for a time-sensitive determination.
- Requests for continued rehabilitation hospital stay.
- Requests for continued skilled nursing facility (SNF) stay, even if the member has reached the maximum limit.
- Requests for continued home health services.
- First requests for physical therapy within four months of a cerebrovascular accident (CVA), head injury or surgery, or other acute trauma.
- Requests for continued physical therapy within six months of a CVA, head injury or surgery, or other acute trauma.
- First requests for physical therapy within four months of a major joint surgery (for example, hip or total knee).
- Requests for continued physical therapy within six months of a major joint surgery.
- Requests for medication, chemotherapy, radiation therapy, or proposed surgical treatment of a known malignancy.
- Requests for proposed AIDS therapy.
- Requests for proposed experimental treatment for a terminal patient.
- Requests concerning a refusal by the provider to proceed with a scheduled service or test because the participating provider failed to obtain an authorization for a service that was scheduled (for example, surgery scheduled, but no authorization provided for the surgery). This applies to requests for referrals that have already been submitted.
- Requests for service concerning any life- or limb-threatening condition.

If the member complains of severe pain, consider requesting an EOD by determining whether delaying care could seriously jeopardize the life or health of the member or the member's ability to regain function.

An EOD must be provided when a participating provider requests an expedited review or supports the member's request, and indicates that applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

14-Day Extension for Expedited Appeals

An extension of up to 14 calendar days is permitted for a 72-hour appeal only if the extension of time benefits the member. Examples of this are a member needing time to provide the plan with additional information or a member in need of having additional diagnostic tests completed.

The plan makes a decision on an expedited appeal and notifies the member within 72 hours of receipt of the request. If the plan's decision, in whole or in part, is not in the member's favor, the plan automatically forwards the appeal request to CMS contractor, MAXIMUS Federal Services, as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the plan fails to provide the member with the results of its reconsideration within the time frames specified above, this failure constitutes an adverse determination and the plan must submit the file to Maximus Federal Services within 24 hours. The plan must concurrently notify the member in writing that the case file was forwarded to MAXIMUS.

Fax Requests for Expedited Appeals

Fax written requests to the Medicare Advantage Appeals and Grievance Department.

- If a member is in a hospital or skilled nursing facility (SNF), the member may request assistance by faxing a written appeal to the plan.
- The time frame for reviewing standard or expedited appeals does not begin until the plan of the participating physician group (PPG) receives the appeal.

Oral Requests for Expedited Appeals

Oral requests from members for expedited appeals must be documented in writing. The 72-hour time frame begins on the date and the time the request is received orally or in writing, regardless of weekends or holidays, and regardless of whether the MAO participating provider receives the request. Any delay in forwarding such requests could result in non-compliance with CMS expedited appeal requirements.

For additional information regarding documentation of oral requests for expedited appeals, contact the Medicare Programs Member Services Department.

Expedited Appeal Process

Health plans are allowed 30 days to process a standard service appeal. In some cases the member has the right to an expedited, 72-hour appeal. The member can receive 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, which may take up to 30 days. If the request is made or supported by a physician, the plan must grant the expedited appeal request if the physician indicates that the life or health of the member, or the member's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame in processing the appeal request. If a member requests an expedited appeal, the plan evaluates the member's request and medical condition to determine whether the appeal qualifies for an expedited, 72-hour appeal. If not, the appeal is processed within 30 days.

If a member misses the noon deadline to file for immediate quality improvement organization (QIO) review of an inpatient hospital discharge, the member may request an expedited reconsideration with the plan. The member must specifically state that an expedited appeal or a 72-hour appeal is being requested and that the member believes his or her health could be seriously harmed by waiting for the standard appeal to be resolved.

If the plan denies a request for an expedited appeal, it must automatically transfer the request to the standard appeal process and then make its determination as expeditiously as the member's health condition requires, but no later than within 30 calendar days from the date the plan received the request for expedited appeal.

The plan does not delegate member grievances or appeals. All member grievances and appeals (standard and expedited) should be forwarded immediately to the Medicare Advantage Appeals and Grievances Department.

The plan prefers receiving appeals and grievances by fax. This enables the plan to receive, process and resolve the member's issue quickly in accordance with state and federal timeliness requirements.

The plan must also provide the member with prompt oral notice of the denial of the request for an expedited appeal and the member's rights, and subsequently mail to the member within three calendar days of the oral notification, a written letter that:

- Explains that the plan automatically transfers and process the request using the 30-day time frame for standard reconsiderations.
- Informs the member of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the reconsideration.
- Informs the member of the right to resubmit a request for an expedited reconsideration and that if the member gets any physician's support indicating that applying the standard time frame for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function, the request is expedited automatically.
- Provides instructions about the grievance process and its time frames.

The plan and participating providers submitting expedited appeal requests must be prepared to re-submit materials if they are inadvertently sent to the wrong review entity. If a QIO or the independent review entity (IRE) that processes reconsiderations receives a request for an expedited review after the review deadline, it must notify the plan by telephone, so that the applicable appeals process can continue expeditiously. Neither QIOs nor the IRE is responsible for forwarding misdirected records to the appropriate office, so the plan and participating providers submitting expedited appeal requests must be prepared to resubmit the requested information to the correct office, or contact the member to initiate an expedited appeal if the member is filing an untimely fast-track appeal.

Expedited Organization Determination Rules

Provider Type: Physicians

The following rules govern the expedited organization determination (EOD) process:

- The Medicare Advantage (MA) member, authorized member representative, Appointment of Representation (AOR), or participating provider may request an EOD through the MA organization (MAO) orally or in writing.

- Requests for EODs may not be filed with the Social Security Administration District Offices or the Railroad Retirement Board.
- The member or member's representative does not have to make a specific request for an EOD. The plan reviews all requests for service to determine whether they meet the following established criteria:
    - Requests by a participating provider for a time-sensitive determination.
    - Requests for continued rehabilitation hospital stay.
    - Requests for continued skilled nursing facility (SNF) stay, even if the member has reached the maximum limit.
    - Requests for continued home health services.
    - First requests for physical therapy within four months of a CVA, head injury or surgery, or other acute trauma.
    - Requests for continued physical therapy within six months of a CVA, head injury or surgery, or other acute trauma.
    - First requests for physical therapy within four months of a major joint surgery (for example, hip or total knee).
    - Requests for continued physical therapy within six months of a major joint surgery.
    - Requests for medication, chemotherapy, radiation therapy, or proposed surgical treatment of a known malignancy.
    - Requests for proposed AIDS therapy.
    - Requests for proposed experimental treatment for a terminal member.
    - Requests concerning a refusal by the provider to proceed with a scheduled service or test because the provider failed to give an authorization for a service that was scheduled (for example, surgery scheduled, but no authorization issued on which to proceed). This applies to requests for a referral that has already been submitted.
    - Requests for service concerning any life- or limb-threatening condition.

  Health Net considers other requests for EODs if the member complains of severe pain by considering whether delaying care could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Expedited Organization Determination Criteria and Process

Provider Type: Participating Physician Groups (PPG)

An member or physician (regardless of whether the physician is participating with the plan) may request an expedited organization determination (EOD) from Health Net when the member or their physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

EODs may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. However, if a case includes both a payment denial and request for services, the member has a right to request an EOD for the service request.

The member or the member's physician may submit the request either orally or in writing when asking for an EOD. A physician may also provide oral or written support for a member's own request for an EOD.

Requests for Medicare Advantage (MA) EODs may not be filed with the Social Security Administration District Offices or the Railroad Retirement Board.

Participating Physician Group Responsibilities

Participating physician groups (PPGs) must provide an EOD when the treating provider requests it, or supports the member's request, and indicates that applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

PPGs must promptly determine whether the request meets the established criteria for EOD processing, which is as quickly as the member's health permits, but no later than 72 hours.

If a PPG decides the request does not meet the criteria for an EOD review, the PPG must

- Automatically transfer the request to the standard 14-day review.
- Provide the member or authorized representative oral notice (within 72 hours) of the denial of expedited status, including the member's right to file an expedited grievance.
    - Oral notice is followed by written notice to the member within three calendar days. The notice explains:
        - Transfer and processing the request using the 14 day time frame.
        - The member's right to file an expedited grievance if he or she disagrees with PPG's determination.
        - The member's right to resubmit a request for an EOD and that if the member's physician provides supporting documentation indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request is expedited automatically.
        - The expedited grievance process and its time frame.

    If a PPG decides the request meets the EOD criteria, but the service is denied due to lack of medical necessity, or other reason, the PPG must:

- Notify the member orally within 72 hours.
- Provide a written notice within three calendar days after providing the oral notice. When completing the standardized notice PPG indicates the specific reason for the denial that takes into account the member's presenting medical condition, disabilities, and special language requirements.

If a PPG decides the request meets EOD criteria and service is authorized, the PPG must:

- Notify the member of its approval determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. The PPG may notify the member orally or in writing. Mailing the determination within 72 hours is not sufficient; the member must receive the notice within 72 hours.

The PPG may extend the 72-hour time frame by up to 14 calendar days if the PPG justifies a need for additional information and documents how the delay is in the best interest of the member. When PPGs extend the time frames, they must notify the members in writing of the reasons for the delays, and inform members of the right to file expedited grievances if they disagree with the PPGs' decision to grant an extension. PPGs must notify members of determinations as expeditiously as the members' health conditions require, but no later than the expiration of the extension.

If PPGs fail to provide members with timely notice of EODs, this failure in itself constitutes an adverse organization determination and may be appealed.

PPGs must maintain tracking logs for all service requests (including oral requests) in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines.

Expedited Organization Determination Tracking Logs

Health Net and its participating physician groups (PPGs) are required to maintain tracking logs for all service requests and denials in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. The tracking log must include a code or another identifying method to distinguish expedited organization determinations (EOD) from other service requests and denials. Health Net reviews and maintains all logs for reporting purposes.

PPGs are not required to submit copies of any service denial letters, unless specifically requested by Health Net or Health Services Advisory Group (HSAG), California's Quality Improvement Organization (QIO). Only copies of the EOD Organization Determinations, Appeals, and Grievances (ODAG) tracking logs are submitted to the plan. Refer to the Calendar of Required PPG Submissions document for information regarding submission dates.

To ensure accurate reporting, the plan provides an EOD (PDF) ODAG tracking log, which includes submission information. Contact the Delegation Oversight Department to obtain an electronic copy in Microsoft Excel (log must be in Microsoft Excel format).

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, documents containing protected health information (PHI) cannot be submitted via standard, unsecured email; therefore, the plan does not accept tracking logs via standard electronic means. PPGs must submit EOD ODAG tracking logs to the Delegation Oversight Department or the Program Accreditation Department at UMQIMR@healthnet.com. The Delegation Oversight Department reviews and maintains all logs for reporting purposes. For additional information regarding submission of EOD ODAG tracking logs, contact the Delegation Oversight Department.

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:

- Administrative Law Judge
- Appointment of Representation
- MAXIMUS Federal Services
- Organization Determinations
- Procedures and Requirements

- Reconsideration Reversal
- Requesting a Standard Reconsideration

Administrative Law Judge

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

A Health Net Medicare Advantage (MA) member who is dissatisfied with a MAXIMUS Federal Services reconsideration of an appeal may request a hearing before an administrative law judge (ALJ). The member may file this request with Health Net Medicare Advantage (MA) or MAXIMUS. The dispute must involve at least $120. The request for a hearing must be in writing and filed within 60 calendar days from the date of the reconsideration notice. Although the plan may not appeal a MAXIMUS reconsideration decision, it is party to any ALJ hearing.

Both the plan and the member may request that the Medicare Appeals Council review an ALJ's decision if they are dissatisfied with the decision. The request for review must be within 60 days from the date Health Net receives the ALJ hearing decision. The request for appeal may be submitted directly to the Medicare Appeals Council. If the amount in controversy is at least $1,220, Health Net or the member may request judicial review of the ALJ's decision in U.S. District Court. (Amounts are subject to change annually and are established by October of the current year. Refer to www.federalregister.gov for more information.)

Any decision may be reopened by any entity that rendered a decision within four years of the notice of organization or reconsidered determination for just cause, or at any time for a clerical correction, suspected fraud, or to consider new evidence that was not available earlier.

Appointment of Representation

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

In accordance with regulations established by the Centers for Medicare & Medicaid Services (CMS), the member's authorized representative may submit a request for an appeal, file a grievance and obtain an organization determination on behalf of the member. An appointment of representation (AOR) may be in the form of a signed written authorization or through legal documentation, for example, a court-ordered guardianship or conservatorship, durable power of attorney or health care power of attorney.

If a member requests that their representative file an appeal on the member's behalf, the member must provide a written statement formally appointing the individual to act as their representative in filing the appeal. Once the written authorization is received and recorded by Health Net or the participating provider, the representative may obtain information about the member's claim or request for service, submit evidence, make statements about facts and law, and make any request or receive any notice regarding the proceedings to the same extent as the member. The authorized representative has the same legal rights as the member regarding the appeal.

The AOR form - English (PDF) (AOR form - Spanish (PDF)) appointing an authorized representative must include the following:

- Member's name, address and telephone number.
- Medicare identification (ID) number.
- Member's signature and date.
- Representative's signature and date, accompanied by a statement that the individual accepts the appointment as representative (if an attorney is representing the member, only the member's signature is required).
- Name, address and telephone number of the individual being appointed representative
- A statement that the member authorizes the representative to act on the member's behalf for the claims at issue, and a statement authorizing disclosure of individually identifying information to the representative.

All notices or other correspondence intended for the member must be sent to the member's representative instead of the member.

The following are examples of special circumstances when an AOR form is not necessary:

- If a member has a court-appointed guardian or health care proxy under state law.
- If a member is not physically or mentally competent to sign an AOR form.
- If a physician requests an expedited review on behalf of a member.
- If a treating physician, upon notifying the member, acts on behalf of the member.
- If an estate representative submits an appeal request on behalf of a deceased member. In this case, obtain a copy of the order appointing the estate representative before opening the appeal case. If the documentation is unavailable, and the representative is an immediate family member, the appeal case may be opened.

Once an appeal is initiated, the party who initiated the appeal may withdraw it. The withdrawal request must be in writing. The member should be contacted to determine whether they agree with the request to rescind the appeal and, if they agree, the request must be in writing.

MAXIMUS Federal Services

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

If Health Net Medicare Advantage (MA) upholds the initial determination in whole or in part, or fails to provide the member with a reconsideration determination within 30 days (pre-service) or 60 days (post-service) of the receipt of the request, it must forward the case file to the Centers for Medicare & Medicaid Services' (CMS) contractor, MAXIMUS Federal Services, no later than 30 calendar days (pre-service) or 60 calendar days (post-service) after receiving the reconsideration request. Health Net concurrently notifies the member that it has forwarded the case to MAXIMUS. Health Net prepares the file for MAXIMUS by providing the following:

- Cover sheet with member name and health insurance number
- Case summary
- Chronology of events
- Supporting documentation
- Reconsideration checklist (used to assure that the file has what is needed - not to be submitted to MAXIMUS)

If the decision is overturned by MAXIMUS, following its receipt of notice of the overturn, Health Net must pay, authorize or provide the service in question as quickly as the member's health requires, but no later than 30 days from notification that payment is required for post-service appeals, no later than 72 hours from notification that an authorization must be made, or no later than 14 days from notification that a service must be provided for pre-service appeals, respectively. Health Net is required to comply with the decision made by MAXIMUS and must inform MAXIMUS of the action taken. After the decision is adjudicated, Health Net can appeal a MAXIMUS decision, and then that final MAXIMUS determination is binding on the plan and the participating physician group (PPG).

Organization Determinations

Provider Type: Participating Physician Groups (PPG)

When a Health Net member, the member's physician or the member's authorized representative has made a request for a service, Health Net and its delegated participating physician groups (PPGs) must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.

Health Net or PPGs may extend the time frame up to 14 calendar days. This extension is allowed to occur if the member requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-participating providers may change the decision to deny). When Health Net or a PPG grants itself an extension to the deadline, it must notify the member, in writing, of the reasons for the delay, and inform the member of the right to file a grievance if they disagree with the Medicare health plan's decision to grant an extension. Health Net or PPGs must notify the member, in writing, of the determination as expeditiously as the member's health condition requires, but no later than the expiration of any extension that occurs.

Pre-Service Organization Determination

A member, or a participating provider acting on behalf of the member, has the right to request a pre-service organization determination if there is a question as to whether an item or service is covered by Health Net. If Health Net denies the member or the participating provider's request for coverage as part of the organization determination process, Health Net provides the member and provider, as applicable with the standardized Notice of Denial of Medical Coverage.

Organization Determination Review

If Health Net or a PPG expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical or other expertise, including knowledge of Medicare coverage criteria (from the National Coverage Determination, Local Coverage Determination and National Coverage Determination Manual), before issuing the organization determination. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in the United States. Note: The physician or other health care professional must remember to apply

the prudent layperson standard (42 CFR 422.113(b)(1)) when making organization determinations regarding emergency services.

Notice Requirements for Standard Organization Determination

If Health Net or a PPG denies services or payments, in whole or in part, or discontinues or reduces a previously authorized ongoing course of treatment, it must give the member a written notice of its determination.

Health Net or the PPG must provide notice using the most efficient manner of delivery to ensure the member receives the notice in time to act (for example, fax, hand-delivery or mail). If the member has a representative, the representative must be given a copy of the notice. The written notice of determination may be a separate document from any plan-generated claims statement to the member or provider. Such other generated statements may include Explanations of Benefits (EOBs), detailing what the plan has paid on the member's behalf, or the member's liability for payment.

If Health Net or a PPG fails to provide the member with timely notice of an organization determination, this failure itself constitutes an adverse organization determination and may be appealed.

Health Net or the PPG must use the approved notice language (such as the Integrated Denial Notification - Notice of Denial of Medical Coverage (IDN-NDMC) and Integrated Denial Notification - Notice of Denial of Payment (IDN-NDP)). If Health Net or the PPG uses its existing system-generated notification (such as the EOB) as its written notice of determination regarding payment denials, the plan or the PPG must ensure that the EOB contains the OMB-approved language of the IDN-NDP verbatim and in its entirety, and meets the content requirements listed in the IDN-NDP's form instructions.

The standardized denial notice forms have been written in a manner that is understandable to the member and must provide:

- The specific reason for the denial that takes into account the member's presenting medical condition, disabilities and special language requirements, if any
- Information regarding the member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3))
- For service denials (using the IDN-NDMC), a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- For payment denials (using the IDN-NDP), a description of the standard reconsideration process and time frames, and the rest of the appeals process
- The member's right to submit additional evidence in writing or in person

Examples of Unacceptable/Acceptable Denial Rationale

Health Net and the PPG must provide enough information for the member to understand the reason for the request denial.

Below is an example of unacceptable denial rationale because it is not specific enough or does not provide the background necessary to indicate why rehabilitation services are no longer necessary:

- You required skilled rehabilitation services - Physical therapy for mobility plus gait, including ADLs, swallowing evaluation and speech therapy - are no longer needed on a daily basis

The denial rationale must be specific to each individual case and written in a manner that a member can understand.

Below are examples of language that are acceptable because they provide detail sufficient to guide the member on any further action, if necessary:

- The case file indicated that while Jane Doe was making progress in her therapy programs, her condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that she reached her maximum potential in therapy. She had progressed to minimum assistance for bed mobility, moderate assistance with transfers, and was ambulating to 100 feet with a walker. The speech therapist noted that her speech was much improved by 6/5/2015, and that her private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.
- Home health care must meet Medicare guidelines, which require that you are confined to your home. You are not homebound and consequently the home health services requested are not payable by Medicare or the Medicare health plan.
- Golf carts do not qualify as durable medical equipment (DME) as defined under Medicare guidelines. Medicare defines DME as an item determined to be necessary on the basis of a medical or physical condition, is used in the home or an institutional setting, and meets Medicare's safety requirements. A golf cart does not meet these requirements and is not payable by Medicare or Health Net.

In cases involving emergency services, Health Net and the PPG must apply the prudent layperson standard when making the organization determination, as described under 42 C.F.R. 422.113(b)(1).

Notice Requirements for Non-Participating Providers

If Health Net or a PPG denies a request for payment from a non-participating provider, Health Net or the PPG must notify the non-participating provider of the specific reason for the denial and provide a description of the appeals process. Plans must deliver either a remittance advice or similar notification that includes the following information:

- Non-participating providers have the right to request a reconsideration of the plan's denial of payment.
- Non-participating providers have 60 calendar days from the remittance notification date to file the reconsideration.
- Non-participating providers must include a signed Waiver of Liability form holding the member harmless regardless of the outcome of the appeal (include either the form or a link to the form).
- Non-participating providers should include documentation, such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement.

- Non-participating providers must mail the reconsideration to the plan (provide appropriate plan address).

Failure to Provide Timely Notice

If Health Net or the PPG fails to provide the member with timely notice of an organization determination, this failure itself constitutes an adverse organization determination and may be appealed.

Procedures and Requirements

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

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage organizations (MAOs) and delegated participating providers to have a process in place for members to appeal all service and claim denials. If Health Net or one of its participating providers denies a request for service, or a request for authorization of a payment or claim, in whole or in part, it is defined as an adverse organization determination or denial. Health Net does not delegate member appeals and grievances. All Health Net MA member appeals and grievances should be forwarded immediately to the Health Net MA Appeals and Grievances Department. Health Net prefers receiving appeals and grievances by fax, which enables Health Net to process and resolve a member's issue quickly in accordance with state and federal timeliness requirements.

A member's communication of an appeal may also include a grievance. Multiple issues are handled simultaneously, but separately under the specific time frames for an appeal or grievance. Each case is cross-referenced in Health Net's correspondence back to the member. The two procedures are mutually exclusive and the appeals procedure does not include binding arbitration.

Initial Determination

An initial determination is made when either Health Net or the participating provider denies payment for a service rendered or fails to provide for or authorize a requested service. Health Net or the participating provider must make an initial decision on a request for service as quickly as the member's health permits, but not later than 14 calendar days from the date of the member's request. This time frame may be extended up to an additional 14 calendar days, if it is in the member's interest.

Health Net must pay 95 percent of clean claims from non-participating providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of the request.

Failure to make an initial determination within the allowed time frame is deemed an adverse determination and automatically entitles the member a right to use the reconsideration and appeals process. In this situation, the member is not held to the 60-day time limit to file a request for reconsideration, and Health Net or the participating provider may be required to pay the claim or provide the service.

Requesting an Appeal

CMS defines an appeal as:

- Any of the procedures that deal with the review of an adverse organization determination regarding health care services a MA member believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (that such a delay would adversely affect the health of the member), or on any amounts the member must pay for a service.

When Health Net or a participating provider denies payment for a service rendered or fails to provide for or authorize a service requested, an appeal for reconsideration of the initial decision may be submitted to the Health Net MA Appeals and Grievances Department or the participating provider. CMS requires all requests for standard or service appeals be made in writing within 60 calendar days of the date of the written denial notice.

An extension of this time frame may be granted if the requestor demonstrates good cause for the delay in filing the appeal. The member may file this request with Health Net or their participating provider.

A member has the right to appeal any decision about payment of, or failure to arrange or continue to arrange for, what the member believes are covered services (including non-Medicare covered benefits) under Health Net's MA plan. This includes any denied medical service that the member feels Health Net should cover. Claims and requests for services must be denied before they can be appealed.

Some commonly appealed decisions include decisions regarding:

- Payment for emergency services, out-of-area urgently needed services, renal dialysis, or post-stabilization services.
- Payment for health services furnished by a non-participating medical group, provider or facility that the member believes should have been arranged for, furnished or reimbursed by Health Net.
- Services that the member has not received, but for which the member believes Health Net should arrange and pay.
- Health Net's discontinuation of services, or refusal to pay for or provide services, that the member believes are medically necessary covered services.
- Prescription copayments the member feels that he or she should not have to pay.
- General claim denials.

The following individuals have a right to request an appeal:

- The member.
- An authorized representative or assignee of the member. An authorized representative or assignee is a person authorized by state law who may sign for and make health care treatment decisions for the member. Refer to the Appointment of Representation (PDF) (AOR) (AOR - Spanish (PDF)) topic for more information.
- A legal representative of the member's estate.
- Any participating provider.

Appeal Processing

The CMS requires that MAOs and participating providers have a process in place to record and respond to all member appeal requests. The MAO or the participating provider must receive requests for appeals in writing, and all requests received orally (expedited appeals only) must be documented.

When an appeal is received, Health Net or the participating provider must:

- Document the member information, provider information, appeal issue, and the date and time the request was received.
- Fully investigate the substance of the appeal, including any aspects of clinical care, and obtain all pertinent information including medical records.
- Ensure that the review of the denied service or claim is conducted by an individual who was not involved in making the initial organization determination. If the original denial was based on a lack of medical necessity, the review must be performed by a physician with expertise in the field of medicine that is appropriate for the services at issue.

Health Net MA is required to perform the following:

- Medical director reviews the initial determination.
- Ensure the reconsideration decision is not made by the same person who was involved in making the initial determination.
- Ensure that denials due to lack of medical necessity are reconsidered by the participating provider with expertise in the medical field of the services under appeal.
- Send a notice of the decision to the requesting party stating whether a decision has been made to make full payment or provide the requested service. If the decision has been made to uphold the initial determination, the requestor is informed that the case has been forwarded to MAXIMUS Federal Services.

Notification of Appeal Determination

If Health Net makes a fully favorable decision on a standard pre-service reconsideration, it must issue a notice of the decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but not later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

If Health Net makes a reconsideration determination on a request for payment that is fully favorable to the member, it must issue a written notice of its reconsideration determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.

Reconsideration Reversal

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

If Health Net does not make a fully favorable decision on a standard service reconsideration, and if on reconsideration, Health Net's determination is reversed in whole or in part by MAXIMUS, Health Net must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). Health Net must inform MAXIMUS that it has complied with the decision.

Administrative Law Judge Reconsideration

If MAXIMUS issues an appeal denial upholding a plan denial, and this determination is reversed in whole or in part by the Administrative Law Judge (ALJ), or at a higher level of appeal, then Health Net must authorize or provide the service as expeditiously as the members' health requires, but no later than 60 calendar days from the date it received the notice reversing the MAXIMUS determination. The plan must also inform MAXIMUS that it has complied with the decision.

For additional information, refer to Administrative Law Judge.

Requesting a Standard Reconsideration

Provider Type: Participating Physician Groups (PPG) | Hospitals

A primary care physician (PCP) may submit a standard pre-service reconsideration request on a member's behalf without completing a representation form. If the standard pre-service reconsideration request comes from a participating physician or non-participating physician, and the member's records indicate he or she visited this physician at least once before, Health Net may assume the physician has informed the member about the request and no further verification is needed. If the standard pre-service reconsideration request appears to be the first contact between the member and physician who is requesting the reconsideration, Health Net takes reasonable efforts to confirm the physician has given the member appropriate notice.

Except in the case of an extension of the filing time frame, physicians must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. If a request for reconsideration is filed beyond the 60 calendar-day time frame without good cause for late filing, Health Net dismisses the reconsideration request and sends the written notification, CMS' Notice of Dismissal of Appeal Request, to the provider stating the reason for dismissal. Additionally, Health Net informs the provider of the right to request an independent review of the dismissal and explains that the request for review of Health Net's dismissal should be filed with the independent review entity (IRE) at MAXIMUS Federal Services.

Standard Reconsideration of a Pre-Service Request

Upon reconsideration of an adverse organization determination, Health Net must issue the reconsidered determination as expeditiously as the member's health requires and no later than 30 calendar days from the date Health Net or its delegated PPG receives the request for a standard reconsideration (and promptly forwards the appeal to Health Net). The time frame may be extended by up to 14 calendar days by Health Net if the member requests the extension, or if Health Net justifies a need for additional information and documents how the delay is in the interest of the member. When Health Net extends the time frame, the member must be notified in writing of the reasons for the delay and their right to file an expedited grievance if they disagree with Health Net's decision to grant an extension. When extensions are granted, Health Net must issue its determination as expeditiously as the member's health condition requires, but no later than the expiration date of the extension.

Occasionally, Health Net may not have complete documentation for a reconsideration request. Health Net must make reasonable efforts to obtain all necessary medical records and other pertinent information within the required time limits. If Health Net cannot obtain all relevant documentation, the reconsideration decision must be based on the material available.

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
- Non-Contracting Provider Payment Disputes

Overview

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

The plan's provider dispute resolution process ensures correct routing and timely consideration of provider disputes or appeals. The provider dispute process is used to address participating provider's complaints alleging nonpayment for covered services rendered or denial of coverage for what the participating provider believes to be a covered service. 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 the plan.
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which the plan needs more information in order to process the claim.
- Challenge a request by the plan for reimbursement for an overpayment of a claim.
- 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 the plan for a de novo review within 365 days of the PPG's written determination.
- Challenge PPG or hospital liability for medical services and payments that are the result of the plan decisions arising from member grievances, appeals and other member services actions.
- Challenge capitation deductions that are the result of the plan decisions arising from member billings, claims or member eligibility determinations.

The plan does not charge providers who submit appeals to the Provider Services Center for processing provider appeals and does not discriminate or retaliate against a participating provider who uses the provider dispute process. Further, providers participating through a PPG cannot be charged a processing fee when utilizing the PPG's provider dispute process. Contract disputes between participating providers and their PPGs are included within the scope of this section on provider appeals.

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.

Appeal Procedures

Participating provider appeals must be submitted to the plan or the PPG, depending on contractual relationship, within the timeliness guidelines stated in the Provider Participation Agreement (PPA). If the PPA does not stipulate a specific time frame, the timely filing period includes the year of the date of service plus 365 days.

Provider appeals (PDF) submitted directly by the participating provider or by parties acting on behalf of the participating provider, such as attorneys and collection agencies, are considered appeals.

A written letter of appeal and supporting documentation must be included with the appeal request. Incomplete records delay the review process.

Member appeals follow different and separate guidelines.

Acknowledgement and Resolution

The appealing participating provider is notified in writing that the provider appeal has been received and is provided with the Provider Services Center contact information. Providers can contact the Provider Services Center to check the status of an appeal or dispute. A second letter is sent with a medical director's determination within 30 calendar days of receipt of complete information.

Acknowledgement and Resolution

The appealing participating provider is notified in writing that the provider appeal has been received and is provided with the Provider Services Center Medicare Advantage contact information. Providers can contact the Provider Services Center to check the status of an appeal or dispute. A second letter is sent with a medical director's determination within 30 calendar days of receipt of complete information.

Non-Contracting Provider Payment Disputes

Provider Type: Participating Physician Groups (PPG)

Participating physician groups (PPGs) who are delegated for claims payment also process claim payment disputes submitted by non-contracting providers. A non-contracting provider may submit a claims payment dispute if they believe the payment amount they received for a service provided to a member is less than the amount paid by Original Medicare, or when the provider disagrees with the PPG's decision to pay for a different service or level than billed. Some other reasons for payment disputes are:

- Bundling issues
- Diagnosis related group (DRG) payments

- Downcoding

Delegated PPGs must instruct non-contracting providers who disagree with the PPG's initial payment review determination decision to submit second-level payment dispute requests in writing to Provider Appeals.

Delegated PPGs must use the uphold (PDF) and overturn (PDF) template letters to advise non-contracting providers to contact the plan if they disagree with the PPG's decision.

Grievances

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

The Health Net Medicare Advantage (MA) grievance procedure applies if the nature of the member's complaint deals with involuntary disenrollment, the quality of care given to the member, delay of referral/authorization, access to care concerns, complaints about waiting times in the office, appointment availability, participating provider demeanor and behavior, adequacy of facilities, the primary care physician (PCP) transfer process, delay of payment, or other service-related issues. Requests for reconsideration of an initial determination related to covered benefits are subject to the Medicare appeals process. Participating providers are required to adhere to Health Net's appeals and grievance procedures as outlined in Title 42 of the Code of the Federal Regulations (CFR) section 422.562.

The fact that a member submits a grievance or complaint to Health Net or to the PPG must not affect in any way the manner in which the member is treated by the PPG or receives services from participating providers. Members have the right to express dissatisfaction or concern and to expect prompt resolution without fear of retaliation or adverse effect on the care they receive.

Procedures

A member who is dissatisfied or has a grievance may contact the Medicare Programs Member Services Department with an oral request or submit a written grievance to the Medicare Advantage Appeals and Grievances Department. Appeal requests must be submitted in writing unless the request is for an expedited appeal.

The member must include all pertinent information from his or her Health Net identification (ID) card and the details and circumstances of his or her concerns. Health Net acknowledges receipt of the request to the member within five business days, reviews the grievance and mails written notification to the member advising of the resolution of the grievance no later than 30 calendar days after receipt of the oral or written grievance. If a grievance cannot be resolved within 30 calendar days and a 14-day extension is needed, a letter that includes the reason for the extension is mailed to the member no later than 30 days after receipt of the oral or written grievance.

Health Net Medicare Advantage (MA) members may obtain additional information on member grievance procedures in their Evidence of Coverage (EOC).

CMS Assistance

Members are expected to use Health Net's grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days with no response from Health Net, or the grievance was not satisfactorily resolved by Health Net, the member may seek assistance from the Centers for Medicare & Medicaid Services (CMS). Participating providers may assist the member in submitting a complaint to CMS for resolution and may advocate the member's position to CMS. No participating provider can be sanctioned in any way by Health Net or a participating physician group (PPG) for providing such assistance or advocacy.

CMS requires that the following note be placed in all correspondence pertaining to quality of care grievance cases:

Please note that you may also file a written grievance with the Quality Improvement Organization (QIO) designated for the state of California. Providers and health care experts at the QIO review quality of care complaints made by Medicare members regarding coverage. Contact the QIO for additional information about quality of care grievances.

Eligibility

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

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

Select any subject below:

- COBRA Continuation
- Dual-Eligible Medicare Beneficiaries
- Steps to Determine Eligibility

COBRA Continuation

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

Required Responses to Provider Inquiries Regarding Coverage

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

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

Election Period Requirements

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

- 60 days following the date the qualifying event would cause the qualified beneficiary to lose coverage
- 60 days following the date the notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage

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

Complete Responses During an Election Period

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

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

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

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

Grace Period Requirements

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

Complete Responses During a Grace Period

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

Dual-Eligible Medicare Beneficiaries

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

Full-Benefit Dual-Eligibles

Full-benefit dual-eligible beneficiaries include those individuals who have coverage under both Medicare and Medi-Cal. In accordance with Medicare guidelines, dual-eligible beneficiaries do not have coverage and access to all approved U.S. Food and Drug Administration (FDA) prescription medications and must enroll in a qualified Medicare prescription drug plan to receive prescription medication coverage. Dual-eligible beneficiaries automatically qualify for extra assistance and do not need to apply separately for the assistance.

Monthly prescription drug plan premiums, annual deductible and prescription drug copayment requirements depend on the beneficiary's annual income and resources, in accordance with the U.S. Department of Health and Human Services (HHS) Poverty Guidelines. Refer to the Centers for Medicare & Medicaid Services (CMS) for additional information regarding prescription drug copayments.

Beneficiaries with full-benefit dual-eligible status may voluntarily choose to enroll in a Medicare Part D plan, another Medicare Advantage (MA) health plan that offers prescription coverage, or a standalone prescription drug plan. Beneficiaries who do not enroll in a qualified Medicare prescription drug program are automatically enrolled in one to ensure there is no loss of prescription medication coverage. Full-benefit dual-eligible beneficiaries enrolled in the plan are enrolled in a Medicare prescription drug program offered by the same MA organization.

Full-benefit dual-eligible beneficiaries have additional opportunities to change plans.

D-SNP Members

Health Net, its contracted providers and their downstream entities are responsible for coordination and delivery of all dual special needs plan (D-SNP) patients' Medicare and Medi-Cal benefits regardless of how the member receives their Medi-Cal benefits.

D-SNP members are those who are enrolled in:

1. Wellcare By Health Net (Health Net) plans **AND**
2. Medi-Cal benefits either through the state fee-for-service plan or a managed care plan (MCP) with any health plan.

These patients are NOT responsible for the coordination of their own Medi-Cal benefits.

If your D-SNP patient's MA is through the Wellcare By Health Net (HMO D-SNP) plan but their Medi-Cal benefits are through another MCP, do not refer them to the DHCS for their Medi-Cal benefits or services not covered by Health Net.

D-SNP providers are responsible for identifying a member's Medi-Cal MCP by checking the Department of Health Care Services (DHCS) Medi-Cal eligibility website. Refer to the Medi-Cal Automated Eligibility Verification (PDF) for steps on how to confirm MCP enrollment and care for your D-SNP patient.

If the member is enrolled in Health Net's Medi-Cal plan, refer to the Medi-Cal Eligibility Verification section for more information.

Aligned Enrollment (EAE) D-SNP Members

Exclusively aligned enrollment is when members enroll in a dual eligible special needs plan (D-SNP) for Medicare benefits and in an Medi-Cal Managed Care Plan (MCP)for Medi-Cal benefits operated by the same parent organization for better care coordination and integration.

Exclusively aligned enrollment D-SNPs offer an integrated approach to care and care coordination. The matching Medicare D-SNP and Medi-Cal plans will work together to deliver all covered benefits.

As all members in the plan are also enrolled in the matching Medi-Cal MCP, they can receive integrated member materials, such as one integrated member ID card.

The exclusively aligned enrollment D-SNP plans will be:

- Wellcare By Health Net D-SNP with a Health Net Medi-Cal plan in Los Angeles, Sacramento, and Tulare counties.
- Wellcare By Health Net D-SNP with a CalViva Health Medi-Cal plan in Fresno, Kings, and Madera counties.

Full-Subsidy Eligible Beneficiaries and Enrollment

Other individuals who are full-subsidy eligible beneficiaries who may receive assistance include:

- Recipients of Full Benefit Dual Eligible (FBDE)
- Recipients of Medicare and Supplemental Security Income (SSI) only.
- Recipients of Medicare savings programs (MSPs), such as qualified Medicare beneficiaries (QMBs-plus), specified low-income Medicare beneficiaries (SLMBs-plus) or Qualifying Individuals.

MSP recipients receive additional assistance from the beneficiary's state of residence, which pays for Medicare premiums and/or cost-sharing.

The full-subsidy eligibles listed above automatically qualify for extra assistance and do not need to apply separately. These beneficiaries generally have slightly higher incomes than full-benefit dual-eligible beneficiaries, and Medicaid pays for cost-sharing associated with Medicare, including member premiums.

Low-Income Subsidy Eligibles

Beneficiaries with limited income and resources who do not fall into one of the subsidies described above may still qualify for assistance in paying for Medicare premiums and/or cost-sharing. These beneficiaries must apply for the low-income subsidy (LIS). Beneficiaries may apply for LIS by contacting the Social Security Administration or the state Medicaid office. Generally, the guidelines apply to incomes less than 150 percent of the federal poverty level (FPL) and limited assets. The type of income considered is based on the rules of the SSI program. Monthly prescription drug plan premium, annual deductible and prescription medication copayments depend on the beneficiary's annual income and resources, in accordance with the U.S. Department of Health and Human Services (HHS) Poverty Guidelines. Refer to the CMS for additional information regarding prescription medication copayments.

Beneficiaries with full-benefit dual-eligible status may voluntarily choose to enroll in a Medicare Part D plan, another health plan that offers prescription coverage, or a standalone prescription drug plan. Beneficiaries who do not enroll in a qualified Medicare prescription drug program are automatically enrolled in one to ensure there is no loss of prescription medication coverage. Full-benefit dual-eligible beneficiaries enrolled in the plan are enrolled in a Medicare prescription drug program offered by the same MA organization. CMS facilitates the enrollment.

Full-benefit dual-eligible beneficiaries may switch plans proving they have a valid election period to do so. Refer to the following sources for additional information.

- Understanding Medicare Advantage & Medicare Drug Plan Enrollment Periods
- Understanding Medicare Enrollment Periods

Steps to Determine Eligibility

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

This section contains information on verifying and determining member eligibility.

Select any subject below:

- Eligibility Verification Methods
- Health Net Identification Card
- Termination of Members

Monthly Eligibility Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

Activity Analysis Report

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

Use Eligibility Report to Verify Member Information

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

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

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

Eligibility Verification Methods

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

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

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

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

- Online download the Save Time Navigating the Provider Portal (PDF) booklet for step-by-step instructions.
- Eligibility verification via the provider's clearinghouse. Health Net is a Phase I- and Phase II-certified entity with the Council for Affordable and Quality Healthcare (CAQH) Committee on Operating Rules (CORE) for eligibility responses. Providers must contact their vendor/ clearinghouse to submit transactions via this method using an EDI transaction or clearinghouse product.

Contact the Health Net Provider Services Center for questions about Medicare Advantage members.

Health Net Identification Card

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

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

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

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

Termination of Members

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

On rare occasions, Health Net may terminate a Medicare Advantage (MA) member from the health plan. Providers are contractually obligated to provide the member with necessary medical services until otherwise notified by Health Net. Termination is not retroactive.

Health Net has the right to terminate coverage from this plan under certain circumstances, as described in the CMS Online Manual System on the Centers for Medicare & Medicaid Services (CMS) website at www.cms.hhs.gov/manuals.

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
- Health Net Medicare Advantage Capitation Eligibility Summary Reports by Group and Provider
- Health Net Medicare Advantage Reconciliation Report

Eligibility Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

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

Health Net Medicare Advantage Activity Analysis Report

The Health Net Medicare Advantage Capitation Activity Analysis Report (BRM 30) identifies and summarizes the following membership activity for the reporting period:

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

The Activity Analysis Report is available monthly by site level, but PPGs may request it at the consolidated level. Providers who wish to be informed more often can request to change activity analysis reporting from monthly to weekly. Contact your Health Net Provider Network Management representative to request the change.

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

Additional information on file layouts and formatting of the Health Net Medicare Advantage Capitation Activity Analysis Report is available as follows:

- Sample Health Net Medicare Advantage Capitation Activity Analysis Report (PDF)
- Sample Health Net Medicare Advantage Capitation Activity Analysis Report Field Descriptions - Report key (PDF)
- Government Programs Electronic Media Format - Activity File (PDF)

Health Net Medicare Advantage Capitation Remittance Detail Report

The Health Net Medicare Advantage Capitation Remittance Detail Report (BRM 20) displays the capitation remittance for each member and is used to reconcile monthly capitation payments and review adjustments made to capitation. The amounts reported are the current monthly capitation amounts plus any retroactive or current adjustment amounts. The report lists all members.

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

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

- Sample Health Net Medicare Advantage Remittance Detail Report (PDF)
- Sample Health Net Medicare Advantage Remittance Detail Report Field Descriptions - Report key (PDF)
- Government Programs Electronic Media Format (Remittance Detail File) (PDF)

Health Net Medicare Advantage Eligibility Report

The Health Net Medicare Advantage Capitation Eligibility Report (BRM 42) lists alphabetically all members eligible for at least one day in the reporting month. Participating physician groups (PPGs) must use this report to verify that a member is eligible to receive services. In addition, providers must check the member's effective and cancellation dates to ensure eligibility on a particular day.

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

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

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

- Sample Health Net Medicare Advantage Eligibility Report Field Descriptions - Report key (PDF)
- Government Programs Electronic Media Format - Eligibility Report File (PDF)

Health Net Medicare Advantage Capitation Eligibility Summary Reports by Group and Provider

Provider Type: Participating Physician Groups (PPG)

The Health Net Medicare Advantage Capitation Eligibility Summary Report By Group/Provider (BRM 11) lists, by employer group, the number of members the participating physician group (PPG) has enrolled and identifies each employer group's plan code and specific supplemental benefits the employer group has purchased.

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

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

- Sample Health Net Medicare Advantage Eligibility Summary by Group Report (PDF)
- Sample Health Net Medicare Advantage Remittance Detail Report Field Descriptions - Report key (PDF)
- Eligibility Summary By Group File (PDF)

Health Net Medicare Advantage Reconciliation Report

Provider Type: Participating Physician Groups (PPG)

The Health Net Medicare Advantage SB 260 Reconciliation Report (BRM 28) lists the current month's dollars and enrollment by product type, and the last 18 months of current retroactivity by product type. The Health Net SB 260 Reconciliation Report is provided to all participating physician groups (PPGs) on the Health Net provider portal on a monthly basis.

Additional information is available as follows:

- Sample Health Net Medicare Advantage SB 260 Reconciliation Report (PDF)
- Health Net Medicare Advantage SPC RPT BRM 28 Exhibits I and II (PDF)

Emergency Services

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

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

Select any subject below:

- Coverage Explanation
- Additional Monitoring Responsibilities
- Instructions to Members Regarding Authorization
- Out-of-Area Emergency or Urgently Needed Care
- PPG Responsibilities

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.

Coverage Explanation

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

Emergency care by any licensed provider is covered regardless of where services are performed. Emergency services may be provided inside and outside of the service area.

Medicare individual plans offer worldwide emergency services with $0 copayment. This benefit has an annual maximum of $50,000.

If a member receives emergency care at an out-of-network hospital and needs inpatient care after the emergency condition is stabilized, he or she must have inpatient care at the out-of-network hospital authorized by Health Net. The cost is the cost sharing the member would pay at a network hospital.

For members who are hospitalized at an out-of-network hospital, Health Net may offer to move the member to an in-network hospital when ongoing inpatient care is indicated, however if the member refuses to be transferred, Health Net can not move the member against their will.

Refer to definition of an emergency for more information.

Instructions to Members Regarding Authorization

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

According to the Evidence of Coverage (EOC) or Certificate of Insurance (COI), members are required to adhere to the following instructions regarding emergency services and urgently needed care:

- Emergency services do not require prior authorization; however, the member is required to notify their participating physician group (PPG), primary care physician (PCP) or Health Net as soon as possible so that follow-up care can be coordinated.
- Hospitals are responsible for notifying Health Net of the admission of a Health Net member.
- PPGs and PCPs are available 24 hours a day, seven days a week, to respond to member telephone calls regarding medical care that the member believes is needed immediately. The member's PPG or PCP should evaluate the member's situation and recommend where the member should obtain emergency or urgent care.

Out-of-Area Emergency or Urgently Needed Care

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

For information on out-of-area emergency or urgently needed care, refer to the Emergency Services, Coverage Explanation section.

PPG Responsibilities

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

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

Select any subject below:

- Notification of Admission
- 24-Hour Access
- Emergency Room Closures

Notification of Admission

Participating Physician Groups (PPG)

The treating emergency hospital is required to complete and send the hospital face sheet to the Hospital Notification Unit for hospital admissions within 24 hours or the next business day. The participating physician group (PPG) is required to notify and supply the PPG authorization number to the Medical Management Department if the emergency hospital treatment is authorized, as applicable.

24-Hour Access

Provider Type: Participating Physician Groups (PPG)

The Federal Health Maintenance Organization Act of 1973 requires that the participating physician group (PPG) provide uninterrupted access to medical services seven days a week, 24 hours a day. If the hospital emergency room department or the emergency room physician calls the PPG or the primary care physician (PCP), the PPG or PCP must respond within 30 minutes or the service is automatically authorized (Title 22 CCR, section 51056). PPGs and PCPs may not instruct the emergency room department or the emergency room physician to call back or wait for a physician to return the call at a later time.

PPGs are also required to provide 24-hour access for members and providers to obtain timely authorization for medically necessary care and for circumstances where the member has received emergency care and is stabilized, but the treating provider believes that the member may not be discharged safely. A physician and surgeon must be available for consultation and for resolving disputed requests for authorization.

Authorize Follow-Up Care

The PPG is responsible for authorizing any follow-up care and necessary transfers between hospitals for in-area emergencies.

Emergency Room Closures

Participating Physician Groups (PPG)

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

Encounters

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

This section contains general information about encounter data submission.

Select any subject below:

- Overview
- Dual-Risk Contracts Encounter Data Submission
- Error Notification
- Lien Recoveries
- Noncompliance with Encounter Data Submission
- Professional and Institutional Capitated Encounter Submission Requirements

Overview

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

To comply with the requirements of the Department of Health and Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), the California Department of Health Care Services (DHCS), the California Disproportionate Share Hospital (DSH) Program, the Managed Risk Medical Insurance Board (MRMIB), and the National Committee for Quality Assurance (NCQA), Health Net requires information from its providers on members' use of health services.

Capitated participating physician groups (PPGs), hospitals and ancillary providers are required to provide complete encounter data about professional services rendered to Health Net members. These services include office visits; X-rays; laboratory tests; surgical procedures; anesthesia; physician visits to the hospital; inpatient, outpatient, emergency room, out-of-area, or skilled nursing facility (SNF) services; and all professional referral

services. Capitated participating facilities (and physician groups with dual-risk contracts) are required to provide encounter data no less than monthly about institutionally-based services rendered to Health Net members.

Encounter data submissions must include all member-paid cost-share amounts, such as copayments, coinsurance and deductibles, applicable to the member's benefit. In addition, any rejected encounter data must be corrected and resubmitted in order for complete information and correct member-paid cost-share amounts to be captured and accumulated. Encounter data submission is also an integral part of the Health Net Quality of Care Improvement Program (QCIP) (applicable only for HMO and Point of Service (POS) products) and Healthcare Effectiveness Data and Information Set (HEDIS®). Refer to the Quality Improvement (QI) topic for more information about QCIP.

Dual-Risk Contracts Encounter Data Submission

Participating Physician Groups (PPG) | Hospitals

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

The following applies to Medicare dual-risk contracts:

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

Inpatient Admissions

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

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

Error Notification

Participating Physician Groups (PPG) | Ancillary | Hospitals

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

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

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

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

Lien Recoveries

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

Some hospitals assume the responsibility for collecting third-party recoveries through their contract with Health Net. The hospital may have its own lien right independent of the contractual lien described in Health Net's Evidence of Coverage (EOC) or Certificate of Insurance (COI), in which case the hospital asserts its own lien. It is the participating provider's staff responsibility to coordinate assertion of liens with the hospital and Health Net to avoid duplication or confusion. In the assertion of any lien, the hospital and the participating providers staffs must be clear about the nature and basis of the third-party recovery right they are asserting and any limitations on the lien under the law.

Member Cooperation

If the member refuses to honor the obligation to sign and return the lien form and declines to reimburse Health Net and the participating provider after settling with the third party, the participating provider should not delay or deny providing services or reimbursing the member's claims.

Noncompliance with Encounter Data Submission

Participating Physician Groups (PPG) | Ancillary | Hospitals

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

Professional and Institutional Capitated Encounter Submission Requirements

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

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

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

- Annual Election and Enrollment Periods
- Member Enrollment
- Part D Enrollment
- Subscriber and Member Identification Numbers
- Use of Social Security Numbers
- Administration of New Member Procedure
- Conditions for Transfer Between PPGs
- Member Terminations

Annual Election and Enrollment Periods

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

When a beneficiary first becomes eligible for Medicare, they may enroll during the seven-month enrollment period which begins three months before, includes the month of and ends three months after the member turns 65.

If the beneficiary qualifies for Medicare on the basis of disability, they can join during the seven-month period that begins three months before their 25th month of disability and ends three months after their 25th month of disability.

During the Annual Election Period (AEP) of October 15 through December 7, each year, beneficiaries may enroll, switch, or drop a Medicare Advantage plan or a Medicare Prescription Drug Plan. Coverage begins on January 1, as long as the plan gets the request by December 7.

Additionally, in certain situations, beneficiaries may be able to enroll, switch or disenroll from a Medicare Advantage plan or Medicare Prescription Drug Plan during a special election period (SEP). Examples of these situations include when a beneficiary:

- Moves out of their plan's service area.
- Has Medicaid.
- Qualifies for a low-income subsidy (LIS).
- Lives in an institution (for example, a nursing home).

Enrollment guidelines for Special Needs Plans (SNPs) are different. The SEP applies to an SNP, but lock-in to a particular plan for a specified time period does not apply to dual-eligible (Medicare and Medicaid) members.

Member Enrollment

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

A Medicare beneficiary must complete and sign the individual election form when enrolling in the Health Net Medicare Advantage (MA) plan. If another person assists the beneficiary in completing the individual election form, that person must also sign the form. If the individual cannot sign, a court-appointed legal guardian or person with durable power of attorney for health care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign. Proof of legal guardian, DPAHC, written advance directive, or proof of authorization by state law is only required when the designated representative is not signing the application that includes the attestation of legal representation. The member's current Medicare coverage continues until the member's coverage with Health Net MA begins.

Generally, the member's enrollment becomes effective the first day of the following month after an election is made. The member's enrollment under any other MA organization or competitive medical plan (CMP) terminates on the effective date of enrollment in the Health Net MA plan. Likewise, enrollment in any other Medicare-contracting health plan or CMP automatically terminates enrollment in the Health Net MA plan.

As long as an individual remains a Health Net MA member, Medicare fee-for-service (FFS) does not process claims for the medical services that the member receives. Health Net MA has financial responsibility for all Medicare-covered health services that the member receives, as long as the member follows the Health Net MA rules stated in these materials and the member's Evidence of Coverage (EOC).

Medicare Advantage HMO

Upon enrollment, Health Net MA members are required to select a Health Net participating primary care physician (PCP) or participating physician group (PPG). The PCP or PPG is responsible for providing or coordinating all of the member's care. By enrolling in the Health Net MA plan, the member agrees to obtain all covered benefits through their Health Net participating PCP or PPG providers, except for emergency, out-of-area urgently needed services, and out-of-area renal dialysis. Additionally, upon enrollment, the member agrees to abide by the rules of Health Net MA.

Application for Coverage

The Medicare-eligible beneficiary must submit a completed Health Net Medicare Advantage (MA) enrollment application, including the signature of the beneficiary and the signature of anyone who assists the beneficiary in completing the application. If the individual cannot sign, a court-appointed legal guardian or person with durable power of attorney for health care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign. Proof of legal guardian, DPAHC, written advance directive, or proof of authorization by state law is only required when the designated representative is not signing the application that includes the attestation of legal representation. The application must be signed by the Medicare-eligible beneficiary prior to the effective date of coverage. No proof of insurability is required. The Medicare eligible beneficiary may be required to submit proof of Medicare Part A and Part B entitlement.

Lock-In Feature

Before joining the Health Net Medicare Advantage (MA) plan, Medicare-eligible beneficiaries should be aware of the lock-in provision that requires the member to obtain most medical care through Health Net MA. This provision is applicable beginning on the effective date of coverage.

Health Net offers the MA plan through a contract with the Centers for Medicare and Medicaid Services (CMS), the government agency that administers the Medicare program. Under this contract, the government agrees to pay Health Net a fixed monthly amount to provide health care to the member.

While a member is enrolled in a Health Net MA plan, Medicare does not pay anyone other than Health Net for the member's health care. Neither Health Net nor Medicare pays for services provided outside of the Health Net MA plan service area, except emergency or out-of-area urgently needed services.

Member Hospitalized At Time of Enrollment

A member who is a hospital inpatient on the effective date of enrollment does not receive inpatient hospital care through the Medicare plan, but continues to obtain these benefits either through Medicare fee-for-service (FFS) or the Medicare-contracting health plan the member belonged to at the time of admission. In this situation, the

plan becomes responsible on the day after discharge. the plan assumes responsibility for all other coverage (except inpatient hospital care) on the effective enrollment date.

Member Identification Card

Upon enrollment in any plan, members receive an identification (ID) card. All plan member ID cards contain the Health Net logo. Information specific to the member's coverage, may include plan name, plan type, group ID, primary care physician (PCP) office visit copayment, and supplemental benefit information, such as pharmacy coverage, located on the front of the ID card. The member's enrollment form may be used in place of the member ID card when the member requires services prior to receiving the ID card. A member ID card or enrollment form does not constitute eligibility under these plans. Participating providers must always verify eligibility prior to rendering services to any member.

To verify eligibility visit the provider portal or contact the Health Net Provider Services Department.

To view a sample of the ID cards, refer to the Identification Cards topic.

Part D Enrollment

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

Individuals entitled to Medicare Part A or enrolled in Part B are eligible for Prescription Drug Plans (PDPs). The beneficiary must have both Parts A and B coverage to enroll in a Medicare Advantage Part D (MA-PD) plan. Additionally, dual-eligible participants and beneficiaries with limited income and resources who qualify for both Medicare and Medicaid are required to enroll in a Medicare prescription drug program to maintain coverage for prescription medication.

A beneficiary is not eligible for Part D when they are incarcerated or live abroad.

Subscriber and Member Identification Numbers

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

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

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

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

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

Use of Social Security Numbers

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

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

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

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

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

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

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

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

Participating providers are subject to the same regulations.

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

Administration of New Member Procedure

Provider Type: Participating Physician Groups (PPG)

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

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

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

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

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

Conditions for Transfer Between PPGs

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

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

Select any subject below:

- Just-Cause Request to Transfer
- Voluntary Transfers Between PPGs

Just-Cause Request to Transfer

Provider Type: Participating Physician Groups (PPG)y

Member-Initiated Just-Cause Transfers

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

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

PPG-Initiated Just-Cause Transfers

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

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

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

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

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

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

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

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

PCP-Initiated Just-Cause Transfers

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

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

Voluntary Transfers Between PPGs

Provider Type: Participating Physician Groups (PPG)

Member Transfers Between PPGs in Different Regions

When a Medicare member moves from one plan contract area to another plan contract area, the member must re-enroll with the plan. The procedure for members transferring to a different region is:

- The member must notify the plan of their relocation and sign a new application form. This action disenrolls the member from their previous plan and enrolls the member into the Medicare plan.
- When the plan receives the new enrollment form, the member is transferred to a participating physician group (PPG) in the new contract area.
- When Centers for Medicare and Medicaid Services (CMS) confirms the member's new contract area enrollment, the plan sends the member a confirmation letter and a new identification card that reflects the member's new contract area PPG.

- The member's selected PPG is liable for the member's health care until the member's name is removed from the eligibility list.

Member Transfers Between PPGs in Same Region

In accordance with CMS guidelines, members may transfer between PPGs without an annual limitation. These unlimited transfer requests may be made at any time by the member. The effective date of transfer is the first day of the following month. For example, if a member requests a PPG change on July 29, the eligibility date with the new PPG is effective August 1.

All transfer requests are screened and handled by the Member Services Department. The procedure for transferring members between PPGs in the same region is:

- The plan notifies both the incoming and outgoing PPGs, as well as the member, that the transfer has been completed.
- The existing PPG assumes the expense for reproducing the member's medical records when the member transfers to another PPG.
- The effective date of eligibility with the new PPG is the first of the following month.

Mid-Month Transfers Between PPGs

In cases where a member relocates and makes a mid-month transfer to a PPG in a different region, the receiving PPG is responsible for all care, unless otherwise negotiated and agreed on by both PPGs and the plan at the time of the transfer.

The plan has the right to require a PPG to accept a mid-month transfer if based on relocation, with the capitated funds apportioned according to the date of the transfer.

PPGs continue to contact the Member Services Department to coordinate mid-month transfers.

Member Terminations

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

This section contains general information on termination of member coverage.

Select any subject below:

- Process for Requesting Termination or Transfer

Process for Requesting Termination or Transfer

Provider Type: Participating Physician Groups (PPG)

All Levels of Behavior

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

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

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

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

- When sending the T/T Request Unit, the notification letters and T/T Incident Report, include all documentation relating to the incident. The plan and the PPG must have thorough documentation of each occurrence as a former member may take legal action. To ensure that all documentation is current, it is important for the PCP to go through the PPG administration department in contacting the plan.
- Any T/T Incident Report received in the T/T Request Unit without a copy of the member notification letter is considered incomplete and is returned to the originating PCP or PPG
- The T/T Request Unit staff assesses the member's warning level and any possible transition of care concerns.
- A copy of the T/T Incident Report is forwarded to the appropriate provider relations & contracting specialist (formally provider network administrator).
- The plan must receive the member's statement within 20 calendar days from the time of the plan's receipt of the PPG's notification letter to allow the plan an opportunity to mediate the situation informally

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

Level A Behavior

Level A behavior is:

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

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

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

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

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

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

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

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

Level B Behavior - HMO & Medicare

Level B behavior is:

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

abusive that the physicians involved determine that the member-physician relationship has deteriorated to such a level that it cannot be resolved satisfactorily to both parties

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

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

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

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

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

Level C Behavior

Level C behavior is:

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

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

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

- Obtain legal counsel to determine the validity of the charge (fraud cases).
- Inform the member by certified mail that the PPG has requested transfer or termination and offer the member an opportunity to respond.
- Inform the provider relations & contracting specialist (formally provider network administrator) of the incident.

- Examine documentation to determine if transfer or termination is warranted with assistance from the regional medical director, Legal Department and Case Management Department, as appropriate.

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

ID Cards

Provider Type: Physicians | 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 their name, physician or participating physician group (PPG)
- The medical plan changes at renewal.

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

- Identification card (Wellcare By Health Net) (PDF)
- Identification card (Medicare Advantage Seniority Plus) (PDF)
- Identification card (Medicare Advantage Prescription Drug Plan) (PDF)
- Identification card (Wellcare Dual Align 129) (PDF)

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

Medical Records

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

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

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

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

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

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

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

Provision of Medical Records

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

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

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

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

Access to Records and Audits by Health Plan

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

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

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

EMR Access

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

Written Protocols

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

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included
- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)

- Formal system for the availability and retrieval of medical records - Policy and procedure must allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - Policy and procedure must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with state laws and regulations (for providers who see commercial health plan patients)
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicare patients)
- Preventive care guidelines for pediatric and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of member information

For more information, select any subject below:

- Confidentiality of Medical Records
- Medical Record Documentation

Confidentiality of Medical Records

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

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. 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.

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.

Basic Principles

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

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

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

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

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

- Written or oral communication whereby the communicator receives no compensation from a third party

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

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

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

Procedure

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

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

Release of medical information guidelines must address:

- Requests for PHI via the telephone

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

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

- A specific and meaningful description of the information to be used or disclosed
- The name of the person or entity authorized to make the requested use or disclosure
- The name of a person or entity to which the use or disclosure may be made
- A description of each purpose or use for the information. If the individual requests the authorization for their own purposes, the description here may read simply "at the request of the individual"
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- The signature of the individual and the date
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation
- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization, unless a valid exception applies (such as, pre-enrollment underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule

Medical Record Documentation

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

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

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

For more information, select any subject below:

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

Advance Directives

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

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

Medical Record Documentation Standards

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

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

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing impaired persons, individual personal biographical information, emergency contact, and identification of the member's assigned primary care physician (PCP)
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the ofference of advance health care directive information and education to members ages 18 and older must be included

- Routine record keeping - Department of Managed Health Care (DMHC) regulations require that the refusal of interpreter services for a Health Net member must be documented in the medical record. Department of Insurance (CDI) regulations also require that, when a minor, or friend or family member interprets at a member's request, even when a qualified interpreter is offered and available at no charge, the offer and the refusal at each visit it occurs shall be documented in the member's medical record
- Coordination of care - Notation of missed appointments, follow-up care and outreach efforts, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans
- Preventive care
    - Adult preventive care - Notation of periodic health evaluations according to the United States Preventive Services Task Force (USPSTF); assessment of immunization status and the year of the immunization(s); tuberculosis screenings and testing; blood pressure and cholesterol screenings; Chlamydia screenings for sexually active females to age 25 or at risk; and mammograms and Pap tests for females
    - Pediatric preventive care - Notation of age-appropriate physical exams according to the American Academy of Pediatrics (AAP); immunizations specified and within AAP and Healthcare Effectiveness Data and Information Set (HEDIS®) requirements; anticipatory guidance for age-appropriate levels; vision, hearing, lead, and tuberculosis screenings and testing; and nutrition and dental assessments
    - Perinatal preventive care - Notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, including a timely prenatal visit within the first trimester; postpartum visit three to eight weeks after delivery - this interval may be modified according to the needs of teh patient, such as HEDIS timlines of 21-56 days after delivery; domestic violence and abuse screenings; HIV, alpha fetoprotein (AFP) and genetic screenings; and assessments of infant feeding status

Medical Record Performance Measurements

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

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

Medical Record Forms and Aids

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

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

Select any subject below:

- Medical Record Forms and Aids

Medical Record Forms and Aids

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

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

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

Member Rights and Responsibilities

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

This section contains general information on member rights and responsibilities.

Select any subject below:

- Advance Directives

- Member Rights and Responsibilities

Advance Directives

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

The federal Patient Self-Determination Act (PSDA) applies to all Medicare providers and states that any health care facility that participates in Medicare or Medicaid programs must inquire about a member having completed an advance directive. This law also requires health care providers to educate their staff and community about the importance of advance directives. Providers should consider discussing advance directives during routine office visits with Health Net members, instead of waiting until a member is acutely ill.

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

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

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

- The advance directive contains the date of its execution
- The advance directive is signed either by the member or in the member's name by another adult in the member's presence and at the member's direction
- The advance directive is either acknowledged before a notary public or signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675 of the California Probate Code
- If the advance directive is acknowledged before a notary public, and a digital signature is used, the digital signature must meet all of the following requirements:
    - It either meets the requirements of Section 16.5 of the Government Code and Chapter 10 (commencing with Section 22000) of Division 7 of Title 2 of the California Code of Regulations, or the digital signature uses an algorithm approved by the National Institute of Standards and Technology
    - It is unique to the person using it
    - It is capable of verification
    - It is under the sole control of the person using it
    - It is linked to data in such a manner that if the data are changed, the digital signature is invalidated
    - It persists with the document and not by association in separate files
    - It is bound to a digital certificate

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

Medicare Advantage Responsibilities and Procedures

Health Net Medicare Advantage (MA) responsibilities for advance directives include:

- Providing written information to all adult members (both Medicare and non-Medicare) at the time of enrollment concerning their rights under California law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, such as living wills or durable powers of attorney for health care (DPAHC)
    - If a member is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition, a mental disorder, or inability to articulate whether the member has executed an advance directive), Health Net MA may give advance directive information to the member's family or surrogate. Follow-up must be performed to ensure that once the member is no longer incapacitated, the information is delivered directly to the member in a timely manner
- If a member submits an advance directive directly to Health Net MA, it must be forwarded to the member's participating physician group (PPG), primary care physician (PCP), or attending physician
- Health Net MA must not condition the provision of care, or otherwise discriminate, on the basis of whether a member has executed an advance directive
- Health Net monitors PPGs to ensure compliance with requirements of state law respecting advance directives
- Health Net is a Medicare Advantage Organization (MAO) and is not required to provide care that conflicts with advance directives
- Health Net provides or arranges for education of Health Net staff, PPG or PCP office staff, and the community regarding advance directives:
    - Education materials should define what constitutes an advance directive and emphasize that an advance directive is designed to enhance an incapacitated individual's control over medical treatment
    - Education materials should describe applicable state laws concerning advance directives
    - Community education efforts must be documented

  Health Net informs individuals that complaints concerning non-compliance with advance directive requirements may be filed with the state survey and certification agency.

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

Provider Responsibilities and Procedures

Participating providers are required to:

- Adopt procedures ensuring that any advance directive executed by a member is brought to the immediate attention of the attending physician
- Document in a prominent place of the member's medical records whether they executed an advance directive
- Ensure that the advance directive is filed in a uniform place in the medical record

- Ensure that each physician honor advance directives to the fullest extent permitted under California law. Physicians are not required to provide care that conflicts with an advance directive
- Ensure that the member's primary care physician (PCP), attending physician or health care facility discusses with and provides medical advice to a member regarding advance directives
- Ensure that physicians do not condition the provision of care, or otherwise discriminate, on the basis of whether an individual has executed an advance directive
- Provide or arrange education for participating providers and the community on advance directives:

- Educational materials should define what constitutes an advance directive and emphasize that an advance directive is designed to enhance an incapacitated individual's control over medical treatment
- Educational materials should describe applicable state laws concerning advance directives
- Community education efforts must be documented

- Inform individuals that complaints concerning non-compliance with the advance directive requirements may be filed with the California Department of Health Care Services (DHCS) for Cal MediConnect members and the State Survey and Certification Agency for Medicare Advantage (MA) members

Hospitals or other health care facilities are required to:

- Ask if the Health Net member has completed an advance directive and if the member has a copy
- If the Health Net member has not signed an advance directive form, the hospital should have an advance directive form available and ask the member if they wishes to sign it. It is the member's choice whether or not to sign
- Ensure that the advance directive is filed in a prominent and uniform place in the medical record (or if the member chooses not sign the advance directive, make a note of that in the medical record)
- If the member decides not to sign an advance directive form, the care cannot be denied, nor should the member incur discrimination
- Inform individuals that complaints concerning non-compliance with the advance directive requirements may be filed with the DHCS for Cal MediConnect members and the State Survey and Certification Agency for Medicare Advantage (MA) members

In no event may participating providers refuse to treat a member or otherwise discriminate against a member because the member has or has not completed an advance directive. For additional information on Advance Directive, refer to the member's Evidence of Coverage (EOC).

Member Rights and Responsibilities

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

Providers must comply with the rights of members as set forth below.

Member Rights

- You have the right to be treated with respect and dignity.

- We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in audio, in braille, in large print, or other alternate formats, etc.).
- You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.
- You have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- We must ensure that you get timely access to your covered services and drugs.
- We must protect the privacy of your personal health information.
- You have the right to look at your medical records held by the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.
- You have the right to know how your health information has been shared with others for any purposes that are not routine.
- We must give you information about the plan, its network of providers, your rights and responsibilities, and your covered services.
- We must support your right to make decisions about your care.
- You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:
    - To know about all of your choices. You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
    - To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
    - The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
- You have the right to make recommendations about our member rights and responsibilities policy.

Member Responsibilities

- Get familiar with your covered services and the rules you must follow to get these covered services.To read their health plan contract in its entirety.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

- To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask and get an answer you can understand. You have the responsibility to understand your health problems and help set treatment goals that you and your doctor agree upon.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
- You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
- If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- If you move within our plan service area, we need to know so we can keep your membership record up to date and know how to contact you.
- If you move outside of our plan service area, you cannot remain a member of our plan. If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Prescription Drug Program

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

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

Select any subject below:

- Medicare Advantage Part B
- Accessing Part D Prescription Medications
- Compounded Medications
- Coverage Explanation
- Generic Medications
- Medication Therapy Management Program
- Participating Pharmacy
- TransactRx

Medicare Advantage Part B

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

Part B Prescription Medication

Health Net may delegate utilization management (UM) for Part B prescription medications to a participating physician group (PPG). Part D covers a broad range of prescription medications, biologicals, vaccines, and insulin, but it does not change current Centers for Medicare & Medicaid Services (CMS) coverage policies under Part B. Some prescription medications, biologicals and vaccines continue to be covered under Medicare Part A or Part B. New medications entering the market meeting the definition of medications covered under Part B become part of the Part B benefit, rather than the Part D benefit.

Part B Coverage

Part B prescription medication coverage is as follows:

- Injectable or intravenous (IV) prescription medications that are administered predominantly by a physician or under a physician's direct supervision as "incident to" a physician's professional service.
- Medications administered "incident to" a physician's service that are usually not self-administered
    - According to CMS, if a medication is self-administered by fewer than 50 percent of Medicare beneficiaries it is considered "not usually self-administered." Determination is made on a case-by-case basis and depends on several factors, including the method, chronicity and frequency of administration.
- Erythropoietin for members with anemia with chronic renal failure who are on dialysis.
- Antigens prepared by a prescriber and administered in the prescriber's office or self-administered by a member who has been appropriately trained.
- IV immune globulin provided in the home setting for members diagnosed with primary immune deficiency.
- Infusion therapies in the home that have been designated by Medicare as requiring the use of an infusion pump (an item of durable medical equipment (DME)).
- Parenteral nutrition provided in the home due to a non-functioning digestive tract
- Inhaled medications administered through a nebulizer.
- Hemophilia clotting factor administered in home to hemophiliac members capable of using the clotting factor without medical supervision in order to control bleeding.
- Certain vaccines, including:
    - Pneumococcal vaccine, if ordered by a prescriber.
    - Influenza vaccine when furnished in compliance with applicable state law.
    - Hepatitis B vaccine if the beneficiary is at high or intermediate risk of contracting the disease, such as:
        - High-risk groups, including:
            - Individuals with end-stage renal disease (ESRD).
            - Individuals with hemophilia who received factor VIII or IX concentrates.
            - Clients of institutions for the mentally handicapped.
            - Persons who live in the same household as a hepatitis B virus (HBV) carrier.
            - Homosexual men.
            - Illicit injectable medication users.
        - Intermediate-risk groups, including:
            - Staff in institutions for the mentally handicapped.
            - Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

- Other vaccines (such as tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.
- Medications packaged under the hospital outpatient prospective payment system.

- Prescription medications furnished as a part of a service in provider settings
  - Medications furnished by ESRD facilities and included in Medicare's ESRD composite rate.
  - Osteoporosis medications provided by home health agencies under certain conditions.
  - Medications furnished by critical access hospitals' (CAHs') outpatient departments.
  - Medications furnished by rural health clinics (RHCs).
  - Medications furnished by federally qualified health centers (FQHCs).
  - Medications furnished by community mental health centers (CMHCs).
  - Medications furnished by ambulances.
  - Separately billable medications provided in comprehensive outpatient rehabilitation facilities (CORFs).

Refer to the CMS Medicare Part B vs Part D Coverage Summary on the CMS website for commonly prescribed medications.

Self-Injectable Medications

Medications that can be self-administered are generally not covered by Medicare Part B. Self-administered medications are covered by Health Net under Medicare Part D . Examples of self-administered medications that are covered under Part B are blood clotting factors, medications used in immunosuppressive therapy, erythropoietin for members on dialysis, and osteoporosis medications for certain homebound members.

Accessing Part D Prescription Medications

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

Members enrolled in a Health Net Medicare Advantage Part D prescription drug (MA-PD) plan can access prescription medication benefits through a Health Net participating pharmacy within their service area. For the highest level of benefits, members must ensure the prescription medication is listed on the Health Net Medicare Part D Formulary. Members may get prescription medications from out-of-network pharmacies under certain conditions.

Part D Prescription Medication Coverage

The Health Net Provider Participation Agreement (PPA) does not cover Medicare Part D benefits.

Part D coverage includes the following when listed in the Medicare Part D Formulary:

- Infusion medications in the home that can be given intravenously, either by gravity or by a disposable (non-durable) pump without the precision of regulating the flow with a DME infusion pump.
- Inhaled medications through a metered dose inhaler.
- Vaccines previously not covered under Part B may be eligible for coverage under Part D.

- Self-administered medications, if self-administered by more than 50 percent of Medicare beneficiaries, as determined by Medicare.

Coverage of some Part D medications is subject to medical necessity review by Pharmacy Services. See Centers for Medicare & Medicaid Services (CMS) for the common Part D vaccines covered under Medicare.

Part D Prescriber Requirements

In accordance with the CMS, 42 CFR 423.120(c)(6), Health Net providers who prescribe Part D medications for Medicare members must be enrolled in Medicare in an approved status, or have a valid opt-out affidavit on file, for medications they prescribe to be covered under Part D. Refer to the CMS website to view the Part D Prescriber Enrollment Fact Sheet

Providers who are currently enrolled in Medicare in an approved status, or have a valid opt-out affidavit on file, should confirm their revalidation status due date on CMS at as soon as possible to avoid a lapse in their Medicare status. The list provides expiration dates up to six months.

Part D Prior Authorization Coverage Determination Requests

In accordance with CMS regulations, the prescriber or member may initiate a prior authorization request for any prescription medication that requires prior authorization.

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.

Prescription medication prior authorization requests by a prescriber can be submitted by telephone or faxed to Pharmacy Services. Members must contact the appropriate Health Net Member Services Department to request prior authorization. Prior authorization request turnaround times are as follows:

- Standard request is 72 hours.
- Expedited request is 24 hours.

Once a decision is rendered (denial or approval), a notification is faxed to the prescriber or pharmacy. The member is notified of the decision in writing and by telephone.

Billing Pharmacy Services for Vaccines

Providers may bill Pharmacy Services directly for Medicare Part D vaccines and their administration using the CMS-1500 form.

Billing the Member

Providers may bill the member for the entire vaccine charge, including the Part D vaccine and administration fee. The member must subsequently submit a paper claim to Health Net for reimbursement. Health Net only reimburses the member Health Net's allowable costs for both the vaccine and the administration. If a prescriber bills a member in excess of Health Net's allowable costs, the additional cost is the member's responsibility.

Submitting a Claim for Vaccines Online

Providers may submit a claim online for the costs of the vaccine and the administration via the TransactRx™ Medicare Part D Vaccine Manager.

Compounded Medications

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

Health Net covers medically necessary compounded medications that contain at least one prescription medication found on the formulary as the primary ingredient. The compound must be within the Food and Drug Administration (FDA)-approved indications. Compounded medications are considered Level III medications and may require prior approval for coverage.

Coverage Explanation

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

Prescription medications are covered under Health Net Medicare Advantage with Prescription Drug (MA-PD) Ruby and Violet plans. Pharmacy coverage is indicated on the member's identification card. All covered prescriptions are listed on Health Net's Medicare Part D Formulary. Some medications may require prior authorization by Health Net.

Health Net individual MA-PD members have coverage up to their coverage limit. The prescription medication dollar limit is combined for brand-name and generic medications. Once a member reaches the coverage limit, the member has to pay full price. It is always in members' best interests to obtain a generic medication when possible to help keep them from reaching the coverage limit. Some members may have unlimited generic prescription medication coverage through the coverage gap.

Coverage for Immunosuppressive Medications

Immunosuppressive medications are covered following a Medicare-covered transplant. This is a basic benefit for all Health Net Medicare Advantage (MA) members whether or not they have a pharmacy benefit.

The member pays a plan-specific coinsurance for immunosuppressants following a covered transplant.

Exclusions and Limitations

The following list of exclusions and limitations (may vary depending on the member's specific benefits) applies to the Health Net Prescription Drug Program as listed in the subscriber's Evidence of Coverage (EOC):

- Medications prescribed by a physician who is not participating with Health Net are not covered except when the physician's services have been authorized because of a medical emergency or the physician is the authorized referring physician.
- Medications dispensed by non-participating pharmacies are not covered, except as specified in the EOC.
- Any medication other than insulin and diabetic supplies that can be purchased without a prescription order over-the-counter is not covered, even if a physician writes a prescription for it.
- Non-prescription contraceptive supplies and devices are not covered.
- Oxygen is not covered.
- Medications prescribed for cosmetic purposes - medications that are prescribed to enhance appearance, including those intended to treat wrinkles or hair loss, are not covered.
- Appetite suppressants or medications used for weight control are not covered, unless for morbidly obese members whose only alternative is surgery (prior authorization required).
- Biological sera, blood, blood derivatives, and blood plasma are not covered.
- Allergy serum to lessen or end allergic reactions are not covered.

Medications prescribed for indications not approved by the Food and Drug Administration (FDA) are not covered unless:

- The medication is prescribed by a participating provider for the treatment of a life-threatening condition.
    - The medication has been recognized for the treatment of that condition by one of the following:
        - The American Hospital Formulary Service (AHFS) Drug Information; or
        - One of the following compendia, if recognized by the federal Centers for Medicare & Medicaid Services as part of an anticancer therapeutic regimen:
            - The Elsevier Gold Standard's Clinical Pharmacology.
            - The National Comprehensive Cancer Network Drug and Biologics Compendium.
            - The Thomson Micromedex DrugDex.
        - Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.
    - The medication is prescribed by a participating provider for a chronic and seriously debilitating condition, the medication is medically necessary to treat that condition, and the medication is on Health Net's Medicare Part D Formulary.

It is the responsibility of the participating provider to submit to Health Net documentation supporting compliance with these requirements.

- Hypodermic syringes and needles are not covered except for insulin needles and syringes.
- Unit individual doses of medication dispensed in plastic or foil packages are not covered unless the packaging is FDA-required.
- Lost, stolen or damaged medications are not covered. The member must pay the retail price to replace them.
- FDA supply amounts for any number of days that exceed the FDA's or Health Net's indicated use recommendations are not covered.
- Prescription medications covered elsewhere in the subscriber's EOC are not covered by the pharmacy benefit.
- Medications prescribed for sexual dysfunction, including medications that establish, maintain or enhance sexual function or satisfaction, are not covered.
- Medical supplies irrigation solutions, durable medical equipment (DME) and blood glucose monitoring supplies are not covered under the pharmacy benefit for Health Net MA plan members. Blood glucose test strips and lancets are covered under the Health Net MA member's DME benefit.
- Nutritional supplements and homeopathic medications or vitamins, except prenatal and children's vitamins with fluoride, are not covered.

Medicare Advantage Prescription Drug Program

Part D is the prescription drug program added to Medicare by the Medicare Modernization Act of 2003 (MMA). It covers a portion of prescription medication costs not historically covered by Medicare. Medicare Advantage Part D (MA-PD) is available to members with Medicare Parts A and B.

Members who do not want Medicare prescription medication coverage may voluntarily opt-out of the MA-PD plan in which they are auto-enrolled and, instead, enroll in one of Health Net's Medicare Advantage (MA)-only plans that do not include prescription medication coverage. Health Net offers MA-PD and MA-only plans for MA members so that members can choose the plan that best fits their needs.

When considering health care options, beneficiaries have the choice of enrolling in a Health Net MA-PD plan that covers all Medicare benefits, including health care services and prescription medications. Under this scenario, members surrender coverage under Medicare and access all health care services through Health Net. Members must follow plan guidelines and access all services, including medical and prescription medication coverage, through Health Net's participating providers. This option provides beneficiaries with maximum cost savings. Medicare prescription drug program pricing for MA-PD is integrated with medical plan pricing.

Medications Not on the Medicare Part D Formulary

Health Net participating prescribers and Health Net participating pharmacies are responsible for following the Health Net Medicare Part D Formulary. If a prescribed medication is not on the applicable formulary, the pharmacist should call the prescriber to request a change to a formulary medication, if appropriate. If the prescriber does not change to a recommended medication due to medical necessity, or one is not available, the prescriber is required to request prior authorization via 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.

The request must document the medical necessity and specify which formulary medications have failed or why the member cannot use a medication on the Medicare Part D Formulary. If approved, the physician receives a faxed authorization that ensures the medication is covered under the member's pharmacy benefit. The pharmacist dispenses the approved medication and charges the member the applicable copayment. Members who have non-Medicare Part D Formulary coverage may receive a medication not on the Medicare Part D Formulary at a significantly higher copayment.

Some Health Net Medicare Advantage (MA) members in specific counties are only eligible for medications that are available generically and on the Medicare Part D Formulary. Even if there are no generics for treating the member's condition, brand-name medications are not covered. Brand-name medications processed through the Health Net claims processor are adjudicated at the Health Net contracting rate with the pharmacy.

Prescription Mail-Order Program

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

For members with Medicare plans, D-SNP plans, Employer Group Waiver Plans (EGWPs) and on/off-exchange Ambetter HMO/PPO plans, the prescribing physician can send requests for new prescriptions via fax to Express Scripts® Pharmacy at 800-837-0959 or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx.

Note: For Employer Group Retiree Drug Subsidy (RDS) members, use CVS Caremark mail order service.

For commercial [non-Individual and Family Plan (IFP)] members, new prescription medication requests may be mailed by the member to the mail order pharmacy or faxed by the prescribing physician. The member's Health Net identification number, date of birth, telephone number including area code, and Health Net should appear on the prescription request to ensure it is processed correctly. If available, a generic equivalent medication is automatically substituted unless the prescriber indicates DAW (dispense as written) or DNS (do not substitute). Members are charged a higher copayment.

Prior Authorization Process

Prior authorization is needed for prescription medication when:

- A medication is listed on the Health Net Medicare Part D Formulary as needing prior authorization or a formulary restriction or limitation is exceeded.

- A medication is not listed on the Medicare Part D Formulary.

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.

Urgent (expedited) coverage determinations for Part D medications are processed as expeditiously as the member's health condition requires but no later than the required time frame (24 hours).

Non-urgent (standard) coverage determination for Part D medications are processed as expeditiously as the member's health condition requires but no later than the required time frame (72 hours).

Faxes are accepted 24 hours a day and each request is tracked to ensure efficient handling of the request.

Prior authorization request forms are available through Pharmacy Services fax-back system; select option 1.

If a prescriber is requesting an exception to the Medicare Part D Formulary or an exception to a utilization management restriction, a written or oral supporting statement is required to indicate that the requested prescription medication should be approved because the alternative medication would not be as effective or would have adverse effects.

Recommended Drug List, Medicare Part D Formulary

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

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

The Health Net RDL and Medicare Part D Formulary are available for review or download from the provider portal.

Generic Medications

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

A generic-equivalent medication is the pharmaceutical equivalent of a brand-name medication for which the brand-name medication's patent has expired. The Food and Drug Administration (FDA) must approve the

generic medication as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name medication.

Generic Substitution Program

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

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

Medication Therapy Management Program

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

As part of the Medicare Part D prescription medication benefit, the Centers for Medicare and Medicaid Services (CMS) mandates that all Part D plans provide a Medication Therapy Management (MTM) program. Health Net's program offers an integrated approach to promoting safe, effective medication use and improving medical outcomes.

Eligibility Criteria

Members who meet all of the following criteria may be enrolled in Health Net's MTM:

- Currently enrolled in a Health Net Medicare Part D plan and
  - Have three or more of the following chronic diseases: chronic obstructive pulmonary disease (COPD), diabetes, depression, dyslipidemia, end-stage renal (ESRD) or osteoporosis.
  - Are taking eight or more chronic Part D medications.
  - Likely to incur an annual total prescription medication cost in excess of $3,967 for 2018 ($4,044 for 2019).

Members enrolled in a Health Net Special Needs Plan (SNP) who do not meet the criteria listed above are enrolled in the MTM program and receive quarterly targeted medication reviews by a pharmacist each calendar year, and may call to speak with an MTM program pharmacist.

Program Description

MTM pharmacists evaluate member's medication profiles and send out customized letters to members and faxes to providers with information about potential medication-related problems. Members are encouraged to discuss the recommendations with their providers, or community or MTM pharmacists. Members continue to be

referred to Health Net's case management program and other wellness programs. For additional information, providers can contact the Health Net MTM program.

Participating Pharmacy

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

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

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

TransactRx

Provider Type: Physicians | Participating Physician Groups (PPG)

TransactRx Vaccine Manager, a product of Dispensing Solutions, Inc., is a website that provides prescribers with real-time claims processing for Medicare Part D office-administered vaccines. This online resource helps alleviate the manual process of billing and reimbursement for vaccines and administrative services.

TransactRx Vaccine Manager allows prescribers to bill Health Net online for vaccines covered under Medicare Part D and their administration.

Enrollment

After completing a one-time online enrollment process at http://enroll.myTransactRx.com, prescribers can:

- Verify member eligibility and benefits in real-time.
- Advise members of their out-of-pocket expenses.
- Electronically submit claims for vaccines covered under Medicare Part D and their administration.
- Receive reimbursement information in real-time.

An authorized staff member should be selected to be the primary user of the system. The following information is required:

- Tax identification (ID) number.
- National Provider Identifier (NPI).
- Medicare ID number.
- Drug enforcement administration (DEA) number.
- State medical license number.

When using TransactRx Vaccine Manager to file a vaccine claim, prescribers must accept Health Net's reimbursement amount plus the members' copayment as payment in full.

Prior Authorizations

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

This section contains general information on prior authorizations requirements.

Select any subject below:

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

Overview

Provider Type: Participating Physician Groups (PPG)

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

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

Authorization for Admission to Hospital or SNF

Provider Type: Participating Physician Groups (PPG)

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

Authorization Requirements for Maternity Inpatient Stay

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

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

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

PPG Must Report SNF - Confined Members to Health Net

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

Diagnostic Procedures

Provider Type: Physicians | Hospitals | Ancillary

Most facilities require a physician-signed order form before performing diagnostic procedures. Referring physicians' requests for prior authorization are processed within 14 calendar days for routine organization determinations and 72 hours for expedited organization determinations after the receipt of all necessary information. An authorization is faxed to the ordering physician and requested facility, and mailed to the member.

All outpatient magnetic resonance (MR), computed tomography (CT), cardiac catheterization, positron emission tomography (PET), nuclear cardiac imaging (including myocardial perfusion imaging (MPI) and multigated acquisition (MUGA) studies), and sleep study diagnostic procedures require prior authorization. For Medicare Advantage (MA) enrollees undergoing PET in Medicare-specific studies, refer to the Medicare-Certified Facilities document under Utilization Management. In addition, for MA enrollees, all advanced diagnostic imaging (ADI) including MRI, CT, nuclear cardiac imaging, and PET must be performed by suppliers

and facilities that are accredited, as defined by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Section 135.

Providers must submit prior authorization requests to Health Net.

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.

PPGs' Responsibilities for Authorization

Provider Type: Participating Physician Groups (PPG)

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

Each PPG is responsible for:

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

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

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

- Records of authorized services - The PPG must keep records of all authorized member services. This allows the PPG to monitor utilization of services by participating physicians and to compare the PPG records to the monthly reports provided by Health Net. Refer to the Medical Data Management Reporting discussion for additional information
- PPGs may not withdraw authorization after services are provided or when a member acts against medical advice - After a PPG authorizes a hospitalization, authorization cannot be withdrawn or payment denied because the member refuses to follow the directions of the attending physician. An example is a member self-discharging from the hospital against the attending physician's medical advice. Refer to the conditions for transfer between PPGs information under the Enrollment topic for additional information
- Collection of copayments for referrals - Refer to the plan chart in the Health Net Schedule of Benefits for each service provided to determine if a copayment is to be collected

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

Prior authorization for DSNP services not covered under Medicare but covered under Medi-Cal for members in Exclusively Aligned Enrollment (EAE) counties

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

DSNP prior authorization timelines

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

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

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

Fax prior authorizations to the Medi-Cal fax number listed under Health Net Prior Authorization 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.

Prior Authorization Process for Direct Network Providers

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

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

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

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

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

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

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

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

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

Emergency services do not require prior authorization.

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:

- Medicare Select Plan Description
- Medicare Plans
- Optional Supplemental Benefits Package

Medicare Select Plan Description

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

Medicare Select Plan Description

The information provided is the most up-to-date as of the date of this publication. For the most up-to-date information, visit providerlibrary.healthnetcalifornia.com

Medicare Select is a type of Medigap policy designed to supplement original Medicare and is made available to those who are entitled to Medicare Parts A and B. Members do not need to choose a primary care physician (PCP) and are not required to obtain referrals or prior authorizations. These are individual coverage plans and are not open to new enrollment.

Medicare Select fills the gaps in Medicare by paying for deductibles, coinsurance and other benefits not covered under the basic Medicare plan. All members pay a monthly premium.

Health Net's existing members have one of the following Medicare Select standard plan designs:

- Plan A
- Plan E
- Plan I without pharmacy
- Plan I with pharmacy

The Medicare Select identification card identifies the Medicare Select plan type A, E or I.

The plan honors all claims for covered services from any Medicare provider and pays on a fee-for-service (FFS) basis using the applicable Medicare Fee Schedule.

Medicare Select Basic Coverage

All Medicare Select members have the following basic coverage:

- Inpatient hospital costs: Covers the Part A coinsurance plus coverage for 365 additional days after Medicare coverage ends.
- Medical costs: Covers the Part B coinsurance (generally 20 percent of Medicare-approved amount) or copayments for hospital outpatient services.
- Blood: Covers the first three pints of blood each year.

Medicare Select Plan A

Medicare Select Plan A is the most limited supplemental plan. This plan covers the basic benefits listed above in the Medicare Select Basic Coverage in addition to Medicare Preventive Care Part B coinsurance.

Medicare Select Plan E

Medicare Select Plan E provides coverage for:

- Basic benefits as listed in the Medicare Select Basic Coverage section.
- Medicare Part A deductible.
- Skilled nursing facility (SNF) care.
- Foreign travel emergency (up to plan limits)*.
- Medicare Preventive Care Part B coinsurance.
- Preventive care not covered by Medicare (up to $120).

*Member must pay a separate deductible for a foreign travel emergency ($250 per year)

Medicare Select Plan I without Pharmacy

Medicare Select Plan I is the most comprehensive supplemental plan offered by the plan. This plan provides coverage for:

- Basic benefits as listed in the Medicare Select Basic Coverage section.
- Medicare Part A deductible.
- Medicare Part B excess.
- Skilled nursing facility (SNF) care.
- Foreign travel emergency (up to plan limits)*.
- At-home recovery (up to plan limits).
- Medicare Preventive Care Part B coinsurance.

*Member must pay a separate deductible for a foreign travel emergency ($250 per year)

Medicare Select Plan with Pharmacy

Medicare Select Plan with pharmacy includes the following:

- Basic benefits as listed in the Medicare Select Basic Coverage section.
- Medicare Part A deductible.
- Medicare Part B excess.
- Skilled nursing facility (SNF) care.
- Foreign travel emergency (up to plan limits)*.
- At-home recovery (up to plan limits).
- Medicare preventive care Part B coinsurance.
- Basic prescription drugs ($1,250 annual limit).

*Member must pay a separate deductible for a foreign travel emergency ($250 per year).

Medicare Plans

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

Wellcare by Health Net offers the following plan types.

Preferred Provider Organization (PPO) Plans

PPO plans offer a wide network of doctors, specialists, and hospitals. Members do not need to choose a Primary Care Physician (PCP) and do not need a referral to see a specialist. Wellcare by Health Net PPO plans come with valuable extras, such dental, vision, hearing, fitness and more.

Health Maintenance Organization (HMO) Plans

Medicare Advantage HMO plans offer access to our wide network of doctors and hospitals, alongside more benefits than original Medicare. With an HMO plan, members have cost-savings by receiving most of their care and services from providers in the plan’s network. Members can expect to choose a Primary Care Physician, or PCP.

Wellcare by Health Net has multiple HMO plan options that provide access to important care. Our HMO plans come with valuable extras, such as dental, vision, hearing, fitness and more.

Special Needs Plans (SNP)

Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

Dual Special Needs Plans (D-SNP)

Dual Special Needs plans (D-SNP) are a special type of Medicare Advantage plan designed to support individuals that also qualify for Medicaid coverage.

- Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). Some, people with QMB+ are also eligible for full Medicaid benefits.
- Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums. Some, people with SLMB+ are also eligible for full Medicaid benefits.
- Full Benefit Dual Eligible (FBDE): Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and co-payments). Eligible beneficiaries also receive full Medicaid benefits.

These plans offer all the coverage of original Medicare plus extra benefits for qualifying members at no cost. Members can get extra benefits like funds for over-the-counter healthcare items (vitamins, toothpaste and more), meal delivery, rides to doctor appointments, pharmacy, and so much more.

Exclusively Aligned Enrollment (EAE) D-SNP Program

Exclusively aligned enrollment (EAE) D-SNPs offer an integrated approach to care and care coordination and are only available in select counties in California.

Enrollment into the EAE D-SNP will result in the member's Medi-Cal plan changing to the same parent organization's Medi-Cal managed care plan. This matching is done by the state of California Department of Health Care Services (DHCS).

The matching EAE D-SNP and Medi-Cal plans will work together to deliver all covered benefits to their members including coordination with Medi-Cal fee-for-service providers.

Chronic Condition Special Needs (C-SNP) plans

Chronic Condition Special Needs (C-SNP) plans take a proactive approach to help manage chronic conditions like diabetes, cardiovascular disease or congestive heart failure. Wellcare by Health Net C-SNP plans are designed to provide cost savings on key medical necessities, like insulin, alongside coordinated care to help manage and reduce potential health risks associated with these conditions.

MEDICARE SUPPLEMENT PLAN

Medicare Supplement plans are identified by the letters A through N. These plans must follow federal and state laws and can only be utilized through a private health plan. The plan offers the following Medicare Supplement plans:

1. Individual Medicare Supplement Plans - Health Net Life Insurance Company offers individual plans A, C, F, High Deductible F, G, K, L, and M.
2. Employer Group Retiree Medicare Supplement Plans - Health Net Life Insurance Company offers plans A, B, C, D, F, High Deductible F, G, K, L, and M. Membership in a Health Net employer group is required in order to be eligible for these plans.

Health Net Life Insurance Company Medicare Supplement Optional Supplemental Packages

Health Net Life Insurance Company offers supplemental benefits for an additional monthly premium with individual Medicare Supplement plans.

1. Optional Package #1 - Hearing care, Standard PPO Dental and PPO Vision
2. Optional Package #2 - Hearing care, Enhanced PPO Dental and PPO Vision

Optional Supplemental Benefits Package

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

Back to previous page

Medicare Advantage (MA) members may purchase additional benefits through Health Net's Optional Supplemental Benefits Packages. The packages may offer routine acupuncture, routine chiropractic, preventive or a comprehensive dental, eyewear and fitness program. These packages may be purchased in various combinations for a monthly premium in addition to the member's monthly Medicare plan premium. Package information is as follows:

- Package 1 - HMO chiropractic and acupuncture, DHMO dental, eyewear, and a fitness program
- Package 2 - HMO chiropractic and acupuncture, DPPO dental, eyewear, and a fitness program
- Package 3 - HMO chiropractic and acupuncture, DHMO dental, and a fitness program
- Package 4 - HMO chiropractic and acupuncture, DPPO dental, and a fitness program
- Package 5 - HMO chiropractic and acupuncture, and DHMO dental
- Package 6 - HMO chiropractic and acupuncture, DPPO comprehensive dental, eyewear, and a fitness program
- Package 7 - HMO chiropractic and acupuncture, and eyewear
- Package 9 - HMO chiropractic and acupuncture, eyewear, and a fitness program
- Package 10 - HMO chiropractic and acupuncture, DPPO comprehensive dental and a fitness program
- Package 11 - HMO chiropractic and acupuncture, and DPPO dental

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:

- Overview
- Calendar of Required PPG Submissions
- Corrective Action Plan
- Fraud, Waste and Abuse

- Member Appeals and Grievances
- Monitoring Provider Exclusions
- Special Needs Plan Model of Care
- Subdelegated Functions
- Contractual Financial and Administrative Requirements
- Delegated Medical Management
- Facility and Physician Additions, Changes and Deletions
- Service and Quality Requirements

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
- Furnishing information regarding regulations
- Developing corrective action plans (CAPs)
- 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 Operations. The Delegation Oversight Committee (DOC) is chaired by the Vice President of Delegation Oversight . The committee meets bi-monthly and is comprised of but not 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 Committees 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 and 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 & Grievances System of record 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 review 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 and grievances process, which conducts an investigation of each issue and tracks trends for quality of care issues by provider, PPG and type of issue. Provider-specific cases are prepared and presented to the Health Net Peer Review Committee for review and action. During the investigation of potential quality of care issues, the QI specialist may request additional information, medical records or implementation of provider-specific action plans from the PPG. Noncompliance with these requests may lead to sanctions, such as freezing enrollment of Health Net members until the issue is resolved or possible termination of the Health Net contract.

Preventive Care Guidelines

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

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

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

Notice to Change PPA

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

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

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

Calendar of Required PPG Submissions

Provider Type: Participating Physician Groups (PPG)

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

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

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

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

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

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

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

Organization Determinations

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

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

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

Reporting Elements & Submission

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

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

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

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

Corrective Action Plan

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a delegated entity is not in compliance with the Plan policies, contractual obligations or regulatory requirements, the Delegation Oversight Department may implement a corrective action process to correct the deficiencies.

- Delegate is notified of deficiency and requested to submit a corrective action plan (CAP) to address the deficiency and implement monitoring measures to avoid reoccurrence of deficiency.
    - The delegation oversight compliance auditor reviews the CAP for appropriateness and completeness and notifies the delegate of whether the CAP is approved.
    - If the Plan does not approve the CAP, the delegate is notified and asked to revise and resubmit the CAP to the Plan.
- If the delegate does not submit a CAP, or complete the actions in their CAP in a timely manner, the deficiency is escalated to the Delegation Oversight Workgroup (DOW), Compliance and Network Management Leadership and or at a JOM to discuss deficiencies or to recommend further actions.
- If the delegate remains deficient it may be escalated to the Delegation Oversight Committee (DOC) to take formal actions up to and including de-delegation.

Fraud, Waste and Abuse

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

Fraud is intentional misrepresentation or deception for the purpose of obtaining payment or other benefits not otherwise due. Abuse includes those practices that are inconsistent with accepted sound fiscal, business or medical practices. The following are examples of fraud and abuse:

- Intentional misrepresentation of services rendered.
- Deliberate application for duplicate reimbursement.
- Intentional improper billing practices.
- Failure to maintain adequate records to substantiate services.
- Failure to provide services that meet professionally recognized standards of health care.
- Provision of unnecessary services .

Health Net is responsible for reporting to the state its findings of suspected fraud and abuse by participating providers or vendors under its Medi-Cal plans. Suspected fraud and abuse is identified through various sources that include aggregate data analysis, review of high-cost providers, review of CPT-4 codes with potential for over-use, members, the state, law enforcement agencies, other providers, and associates.

Providers and their office staff are legally required to report suspected cases of fraud and abuse to Health Net. Reports of suspected fraud may be made anonymously to the Health Net Fraud Hotline.

Member Appeals and Grievances

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

Health Net does not delegate member grievances or appeals. All grievances and appeals should be forwarded immediately to the Appeals and Grievances Department.

Monitoring Provider Exclusions

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

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to these enrollees. Health Net requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP), and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM) website.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

Health Net and Provider Responsibilities

Health Net is required to monitor federal and state exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net plans. Health Net's contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, FEHBP and EEDP federal exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid or Part C and Part D related activities. Health Net, its contracted providers, and their downstream subcontractors or delegated entities must continuously monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website.

The current LEIE is available on the OIG-HHS website. Refer to Frequently asked questions (FAQs) for additional information about the LEIE.

Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare and Medicaid Services to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > References > Suspended and Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers.

Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicare participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR. Search the WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file. The RPD data file is updated monthly and is available at Healthnet.com. Registered providers can log into the provider portal to access the report located under the regulatory section.

Claims Payment For Excluded Parties

Health Net, its PPGs, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except as documented in the CMS Internet Only Manual, publication 100-16, Chapter 6 - Relationships with Providers, which states, "The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR §1001.1901." FDRs contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Health Net or CMS.

Regulatory Citations for Excluded Requirements

Medicare Advantage organizations (MAOs) and their FDRs must abide by the regulations documented in the Social Security Act 1862(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 422.222, 422.224 and 1001.1901. These federal exclusion requirements are further interpreted and communicated as guidance by CMS in the Medicare Manual, Volume 100-16, Chapters 9 and 21 §50.6.8.

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Special Needs Plan Model of Care

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

Wellcare By Health Net (Health Net) provides a coordinated Special Needs Plan (SNP) for members with certain chronic diseases (C-SNP). Providers must attest the member has diabetes, congestive heart failure or cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorders) to enroll.

Health Net also provides a coordinated SNP for members who are dually eligible for Medicare and Medi-Cal/Medicaid (D-SNP).

SNP Model of Care Annual Training

The Centers for Medicare & Medicaid Services (CMS) requires that SNP providers and appropriate staff (those involved in any aspect of the provision of SNP services) complete SNP Model of Care (MOC) Annual Training each year by December 31. The training can be provided in a variety of modalities, such as printed, face-to-face, or online Web-based formats. Wellcare By Health Net (Health Net) requests physicians and other providers who treat SNP members to submit a voluntary attestation after completion of the MOC training, which can be found after completing the training. Remember to provide Model of Care training to new hires in addition to annually for existing staff.

Sub-Delegated Functions

Provider Type: Participating Physician Groups (PPG)

For delegated entities that subcontract with another entity to carry out delegated quality management (QI), utilization management (UM), member connections, and credentialing and recredentialing functions, the

Delegation Oversight Department is enforcing the following National Committee for Quality Assurance (NCQA) requirements:

- QI for quality management
- UM for utilization management
- MEM for member connections
- CR for credentialing and recredentialing

The Plan performs audits and requires that delegated entities demonstrate how they ensure that the subcontractor performing delegated QI, UM, member connections, and credentialing and recredentialing functions on the delegated entities behalf is meeting NCQA standards and any additional regulatory state and/or federal requirements. More specifically, the Plan requires proof of an agreement between the provider group and subcontractor entity that delineates the rights and responsibilities of each party and requirements for review of subdelegated activities.

Definitions

The current Health Plan Standard and Guidelines, published by NCQA, define delegation and sub delegation as follows:

- Delegation - Occurs when the organization (Health Net) gives another entity (such as a participating physician group (PPG) or independent practice association (IPA) the authority to carry out a function that the organization would otherwise perform.
- Sub delegation - Occurs when the organization's delegate (such as a PPG or IPA that contracts with Health Net to perform a specific function) gives a third entity the authority to carry out a delegated function.

Contractual Financial and Administrative Requirements

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

This section contains general information on contractual financial and administrative requirements.

Select any subject below:

- Contracts with Ancillary Providers
- Discrimination against Health Care Professional Prohibited
- Financial Statements
- Financial Survey Filing Requirements
- Maintenance of Financial Records
- Physician Incentive Plan
- PPG Networking Contractual Requirements
- Use of Performance Data

Contracts with Ancillary Providers

Provider Type: Hospitals | Ancillary

The plan may review copies of the hospitals' contracts with its ancillary providers to ensure the contracts meet regulatory requirements. Contracts must include language stating that:

- Members are not liable to the provider for any sums owed by the plan (hold-harmless language).
- Providers may not apply surcharges or any other charges, other than copayments, for covered services.
- Providers must maintain the confidentiality of member information and records.
- Providers must maintain timely, accurate and complete medical records.
- Providers must maintain records for a minimum of ten years.
- Providers must submit encounter data as required.
- Providers must comply with the medical policy, quality improvement (QI) and medical management policies of the plan.
- Providers must allow open provider-member communication regarding appropriate treatment alternatives.
- Providers must comply with applicable state, federal, and Medicare laws, regulations and reporting requirements.
- Contracts may not contain any incentive plan that includes payment as an inducement to deny, reduce, limit, or delay specific, medically necessary and appropriate services.
- Contracts must include accountability provisions.
- Contracts must allow access to medical records, to the extent permitted by law.

Discrimination against Health Care Professional Prohibited

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

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), health plans may not discriminate against the following:

- Any health care professional who is acting within the scope of their license, in terms of participation, reimbursement or indemnification.
- Professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

Health plans are also required to issue written notice to providers regarding the reason the plan is declining to accept the provider or participating physician group (PPG). For additional information regarding provider credentialing, refer to the Credentialing topic.

Financial Statements

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net monitors and evaluates the financial viability of its delegated and capitated participating providers and maintains adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent (section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR)).

All providers with a capitated Provider Participation Agreement (PPA) are required to submit their annual financial statements to Health Net 150 days after the close of the participating physician group's (PPG's) or hospital's fiscal year. PPGs and hospitals are further required to submit to Health Net quarterly financial updates, prepared by the provider organization and reflecting year-to-date activity, within 45 business days after the close of the calendar quarter or most recent quarter, if provider's fiscal year is different from calendar year.

PPGs' and hospitals' financial statement packets should include:

- Signed Health Net financial certification form (for quarterly unaudited financials only).
- DMHC quarterly and-or annual financial survey report forms as detailed in subsection 1300.75.4.2(b) and (c) of Title 28 of the California Code of Regulations (CCR) including:
    - balance sheet
    - an income statement
    - a statement of cash-flow
    - a statement of net worth
    - cash and cash equivalent
    - receivables and payables
    - risk pool and other incentives
    - claims aging
    - notes to financial statements
    - enrollment information
    - mergers, acquisitions and discontinued operations
    - the incurred but not reported (IBNR) methodology
    - administrative expenses
    - footnote disclosures (for annual audited financial survey)

For nonprofit entities, refer to subsection 1300.75.4.2(b) and (c) of the California Code of Regulations for additional requirements.

PPGs and hospitals must submit these quarterly financial updates and annual audited financial statements to the Financial Oversight Department

PPGs and hospitals must also ensure compliance with Health Net's financial solvency standard benchmarks and related contractual requirements to make sure their financial status is stable and not deteriorating over time. If the PPGs and hospitals fail to meet the financial solvency standard, and it is determined by Health Net that a corrective action plan (CAP) is needed, the PPGs and hospitals must submit a CAP within 30 days from the date of request. Below are the 14 financial solvency review standard benchmarks that must be met:

Provider Type	Category	Standard
PPG, Hospital	Working Capital	Must be positive
PPG, Hospital	Tangible Net Equity	Must be positive
PPG	Required Tangible Net Equity	Refer to 1300.76(c)(1) of Title 28 of CCR
PPG	Cash to Claims Ratio	= or > 0.75
PPG, Hospital	Cash to Payable Ratio	= or > 0.50
PPG, Hospital	Profit Margin Ratio	> 0.00
PPG	Medical Loss Ratio	= or < 0.85
PPG, Hospital	Debt-to-Equity Ratio	= or < 1.0
PPG, Hospital	Accounts Receivable Turnover	= or > 11.81
PPG, Hospital	Average Days to Collect	= or < 30 days
PPG	Average Claims Liability	between 2.5 & 3.5 months
PPG	General and Administrative Expenses	= or < 0.15
Hospital	Total Operating Expense	= or < 1.0
PPG, Hospital	Total Z-Score	= or > 1.81

If the PPG is determined to be noncompliant, a corrective action plan (CAP) must be filed simultaneously with the financial survey to the Department of Managed Health Care (DMHC).

PPGs With Sub-Delegating Risk Arrangements

PPGs with sub-delegating risk arrangements are required to monitor and evaluate the financial viability of their delegated and capitated participating providers and maintain adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent according with section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR) and with Health Net's financial benchmark as outlined above. When requested by Health Net, PPGs are required to provide copies of their monitoring policies and procedures within 30 days of Health Net's request.

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	Q1 Q2 Q3 Q4	May 15 August 15 November 15 February 15

Filing Types	Requirements	Filing Period	Filing Deadline
	year must submit the most recent quarter.)		
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 generally accepted auditing standards. Hospitals submit annual audited financial surveys including auditors notes and opinion letter to Health Net directly.	Annual	May 31

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.

Maintenance of Financial Records

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

Participating providers agree that the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), the Comptroller General, or their designees have the right to audit, evaluate and inspect any books, contracts, and computers or other electronic systems, including medical records and documentation related to the plan's Medicare Advantage contracts with CMS. This right exists through 10 years from the final date of the calendar year (the plan's contract year with CMS) in which services are provided.

Maintenance of Records

The plan and its participating providers must maintain books, records, documents, and other evidence of accounting procedures and practices for 10 years. Records must include:

- ownership and operation of the financial, medical and other record keeping systems
- financial statements for the current contract period and 10 prior periods
- federal income tax or informational returns for the current contract period and 10 prior periods
- asset acquisition, lease, sale, or other action
- agreements, contracts and subcontracts
- franchise, marketing and management agreements
- schedules of charges for the Medicare Advantage (MA) organization's fee-for-service patients
- matters pertaining to costs of operations
- amounts of income received by source and payment
- cash flow statements
- any financial reports filed with other federal programs or state authorities

The plan and participating providers must agree to allow access to facilities and records to Department of Health and Human Services (HHS), the Comptroller General or their designees, through inspection, audit or other means.

Physician Incentive Plan

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

The plan does not make direct or indirect payments to a participating provider as an inducement to reduce or limit medically necessary services furnished to any particular Medicare member. Indirect payment may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

If a physician incentive plan is negotiated that places a participating provider at substantial financial risk for services that the participating provider does not furnish itself, the plan ensures that all such participating providers at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with applicable Centers for Medicare & Medicaid Services (CMS) guidelines (42 CFR 422.208 (f); MMCM Chapter 6, Section 80.1). Failure to acquire or maintain appropriate stop-loss protection results in new negotiations to reduce the risk threshold below the maximum limit of 25 percent or termination of the agreement in its entirety.

Primary Care Incentive Payment

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

The Centers for Medicare & Medicaid Services (CMS) provides for an incentive payment for primary care services furnished by eligible nonparticipating providers on or after January 1, 2011, and before January 1, 2016. The 10 percent primary care incentive payment (PCIP) must be paid on either a quarterly basis or with each qualifying claim. For Cal MediConnect providers, these requirements are Medicare-specific and not applicable to Medi-Cal. CMS defines a primary care practitioner as:

- A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine.
- A nurse practitioner, clinical nurse specialist or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the Physician Fee Schedule (PFS) for the practitioner in a prior period as determined appropriate by the Secretary of Health and Human Services (HHS).

Participating providers delegated for claims processing and payments are required to pay the PCIP to primary care practitioners for services delivered in 2014 when all of the following conditions are met:

- Delegated provider does not have an existing contract with the primary care practitioner (therefore, he or she is nonparticipating).
- Nonparticipating primary care practitioner treats a Medicare member.
- Nonparticipating primary care practitioner is listed in CMS' PCIP eligibility file.

Delegated participating providers are required to compare covered primary care service claims paid to nonparticipating primary care practitioners against the National Provider Identifier (NPI) list from CMS. CPT codes 99201 through 99215, and 99304 through 99350 are eligible for the 10 percent bonus. The list can be accessed on the Health Net provider portal.

Additional information about the PCIP program and the CMS MA Payment Guide for Out-of-Network Payments can be obtained through the CMS website at www.cms.gov.

Calculating PCIP

The incentive payment amount is calculated as a percentage of Medicare Part B allowed charges for primary care services, which is the same formula used by original Medicare. Participating providers delegated for claims processing and payments must pay the PCIP unless the total amount owed is less than one dollar. The plan recommends the PCIP be made within 60 days following the close of a calendar quarter.

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
- Inpatient Denial Log Submission

Overview

Provider Type: Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) with delegated utilization management (UM) status are required to consistently meet Health Net's UM standards related to inpatient care, outpatient care, discharge planning, case management, retrospective review, and timeliness of authorizations and denials. Health Net's UM standards are updated as necessary to comply with standards established by federal and state regulatory agencies and accreditation entities, such as the National Committee for Quality Assurance (NCQA). Delegation of UM activities allow for autonomy based on PPG capabilities and creates accountability to Health Net. Health Net audits PPGs for accountability and reporting of PPG activities.

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

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

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

Program Description

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

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

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

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

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

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

Policy Development

The utilization management (UM) criteria or guidelines used to determine whether to authorize, modify, or deny health care services must be evaluated at least annually and updated, as necessary.

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.
- 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

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.

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.

Inpatient Denial Log Submission

Provider Type: Participating Physician Groups (PPG)

Hospitals must notify Health Net of a member's inpatient admission within 24 hours. In addition, Health Net requires delegated participating physician groups (PPGs) to submit information regarding denial of member inpatient admissions on a weekly basis.

Delegated PPGs are required to submit a weekly inpatient denial log (PDF) every Wednesday by close of business for the previous week's inpatient denials. If there are no denials, then the PPG must also submit a log that states that there were no denials for this time period. Providers must use the inpatient denial log and include the following information:

- member name
- member identification (ID) number

- admission and discharge dates
- number of days denied within the current length of stay and the date(s) of denied days
- type of service (for example, obstetrics (OB), skilled nursing facility (SNF), medical/surgical, or intensive care unit (ICU))
- admitting facility name
- authorization or denial number for each level of service during the length of stay
- disposition (such as discharged to home, SNF or hospice)

Submit weekly inpatient denial logs to Health Net via encrypted email, fax or mail.

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
- Closure and Termination
- Conditions of PCP Office Closures
- Facility Decertification Notification Requirement
- Facility and Satellites
- Member Notification for Specialist Termination
- Provider Excluded from Program Participation
- Provider Online Demographic Data Verification
- Provider Outreach Requirement

Overview

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

A participating provider that expands its capacity by adding new or satellite facilities or new participating physicians or other subcontracting providers must notify the plan in writing at least 90 days before the addition. According to the terms of the Provider Participation Agreement (PPA), the participating provider agrees that the plan has the right to determine whether the new or satellite facilities or the new participating physicians are acceptable to the plan.

Addition of New Physicians, Providers and Facilities

Until the plan 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 PPA. The plan must be notified in writing at least 90 days before the addition.

The plan 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. The plan's decision in these cases is final and binding.

In addition, hospitals, ancillary providers and participating physician groups (PPGs) are responsible for providing the plan with copies of the standard agreements used for their subcontractors. The plan reviews these standard agreements to ensure compliance with regulatory requirements1 and directs the facility to make any changes required in order to meet the requirements. The plan requires hospitals, ancillary providers and PPGs to send sample forms to the plan 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 the plan with a copy of the signature page for each subcontractor. Physicians or other subcontractors must be credentialed before they are added to the plan's network. Hospitals, ancillary providers and PPGs must also provide the plan a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals, ancillary providers and PPGs are responsible for informing the plan when they cease to use a specific subcontractor or when they add a new subcontractor. The plan periodically sends each hospital, ancillary provider and PPG a list of the physicians or subcontractors the plan shows as active and under contract with the participating provider. Hospitals, ancillary providers and PPGs are required to review this list and notify the plan of any additions or deletions. At least annually, hospitals, ancillary providers and PPGs must provide the plan with a list of additions, deletions and address changes, as well as a complete listing.

For PPGs only, the Active Physicians Listing is available monthly on the Health Net provider portal under Welcome. Select Provider Reports > Available Reports. This report provides PPGs a means to review and revise their records on a monthly basis and communicate physician demographic changes and terminations to the plan. Additionally, this listing is used by the 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 participating provider contract amendments within 20 days of execution.

[1] Medicare Managed Care Manual, Chapter 11, Section 100.4

Closure and Termination

Provider Type: Participating Physician Groups (PPG)

Participating physician groups (PPGs) are required to notify the 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 Medicare plans, the Plan notifies affected members at least 45 days in advance, whenever possible, of a primary care physician (PCP) termination or a behavioral health provider termination. For PCP terminations, PPGs must provide the Plan with the name of the new PCP as well as two alternative PCPs.

The written notification is sent by U.S. mail, and includes instructions on selecting a new PCP, the newly assigned PCP and two alternative PCPs. For PCPs and behavioral health providers, the Plan must make at least one attempt at telephonic notice to the identified members (unless the member has opted out of calls regarding Plan business). Telephonic provider termination notices must relay the same information as the written provider termination notice.

The Plan must provide written notice to members at least 30 days prior to the termination date for all other contracted providers and facilities.

For Medicare HMO plans, capitated and shared-risk PPGs must notify members in writing at least 30 days in advance of a specialist, behavioral health specialist or ancillary provider termination effective date, and the template sent to members must be approved by the Centers for Medicare & Medicaid Services (CMS).[1] The Plan's CMS-approved Medicare termination notification template (PDF) must be completed by the PPG and mailed to the member.

The Plan 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.

Refer to definition of Opt Out Provider for more information.

[1]Title 42 of the Code of Federal Regulations (CFR) section 422.111(e))

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.

Facility and Satellites

Provider Type: Participating Physician Groups (PPG) | Hospitals

If a facility expands its capacity by adding new or satellite facilities, or new member physicians or other subcontracting providers, the facility must notify the plan in writing at least 90 days before the addition. The plan has the right, in its sole discretion, to determine whether the new or satellite facilities or the new member physicians are acceptable to the plan.

Facilities and Satellite Contracts

According to the terms of the Provider Participation Agreement (PPA), participating physician groups (PPGs) agree not to add new or satellite facilities until the plan has approved them. The plan is free to deny participation under the PPA to any new or satellite facilities, and is not obligated to state a cause or explain the denial of the addition or provide the PPG with any right to appeal or any other due process. The plan's decisions regarding additions to the network are considered final and binding.

Facility Terminations

Facilities are required to notify the regional Provider Network Management Department in writing at least 90 days in advance of the date that a subcontracting provider terminates its relationship with the facility.

Member Notification for Specialist Termination

Participating Physician Groups (PPG)

Delegated participating physician groups (PPGs) must have a written policy regarding member notification when a specialist terminates their contract. The written policy must include the following elements:

- PPGs must notify the plan 90 days prior to a specialist terminating (or as stated in the PPG's Provider Participation Agreement (PPA)).
- PPGs must identify members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist.
- Identified members must be notified by the PPG in writing and the notification must be made immediately upon notification of termination, but no later than 30 calendar days prior to the effective date of the specialist's termination.
- PPGs must help members transition to a new specialist within the PPG's network of participating providers.

If a member with an acute care condition has questions or concerns regarding the continuation of services from the terminating specialist, advise the member to call the Health Net Member Services Department, Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Member Services Department.

Templates for Only Medicare and DSNP Member Notifications

To notify Medicare and DSNP members when a specialist terminates, PPGs must use the applicable template in the table below approved by the Centers for Medicare & Medicaid Services.

Template	H-contract	Product
Medicare Provider Termination Notification Template-MA H0562	H0562	Medicare Advantage
Medicare Provider Termination Notification Template-DSNP H3561	H3561	Dual Special Needs Plans: • Wellcare Dual Align • Wellcare CalViva Dual Align • Wellcare Dual Liberty

Provider Excluded from Program Participation

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

Participating physician groups (PPGs) that are delegated for credentialing must ensure that members are not served by any provider excluded from program participation. PPGs may check the exclusion lists on the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) website at oig.hhs.gov under Exclusions and the Department of Health Care Services (DHCS) Medi-Cal website at www.medi-cal.ca.gov under References>Suspended and Ineligible Provider List. New lists are published each month and the former lists remain. Providers excluded from program participation and providers that have been reinstated are included on the lists. Health Net recommends that PPGs check the lists each month.

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.

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
- Open Clinical Dialogue
- Provider Responsibility
- Claims Denials
- Claims Payment Requirements
- Authorization and Referral Timelines
- Credentialing and Recredentialing
- Eligibility and Data Entry Requirements
- Quality Improvement Problem Resolution

Access to Care and Availability Standards

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

The plan's appointment accessibility and availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care, behavioral health care, urgent care, ancillary services, and emergency care are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards. These access standards are based on and regulated by the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

Note: Behavioral health and chemical dependency services are administered by Health Net.

The plan and its participating providers are required to demonstrate that, throughout the geographic regions for the plan's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible at reasonable times. Additionally, the plan and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within a reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practice. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirement and telephonic access to health care services and monitoring activities to ensure compliance.

Member Notification

Members are notified annually, via member newsletters or the Evidences of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioner (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instruction on after-hours access to medical care.

After-Hours Access Guidelines

As required by applicable statutes, the plan's participating providers must ensure that, when medically necessary, medical services are available 24 hours a day, seven days a week; and PCPs are required to have appropriate back up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or an answering machine to provide members with clear and simple instruction on after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should return telephone calls and pages within 30 minutes and be available 24 hours a day, seven days a week. The PCP or the on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room as medically necessary.

Additionally, the plan provides triage and screening services 24 hours a day, seven days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although the plan does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, seven days a week.

After-Hours Script Template

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues. Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. The plan 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 on how to access care. The plan'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.

The plan makes the script available in the following threshold languages:

- After Hours Sample Script - English (PDF)
- After Hours Sample Script - Chinese/Cantonese (PDF)
- After Hours Sample Script - Spanish (PDF)

After-hours scripts are available in additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

The provider is responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the member's condition so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

The plan 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 facilities.
- If language assistance is needed, offer the member interpreter services, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.

- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted.

In the event of a hospitalization, the PPG or hospital must contact Hospital Notification Unit within 24 hours or the next business day of the admission.

The answering service must document all calls. Answering services frequently have a high staff turnover, so providers should monitor the answering service to ensure emergency procedures are followed.

Triage and/or Screening Services/Nurse Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), Health Net provides 24-hour-a-day, seven-day-a-week triage or screening services by telephone. This program is a service offered in conjunction with the PCP and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment and advice. The Health Net Member Services Department coordinates member access to the service, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide instruction on home and care techniques and general health information.

Health Net ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. Health Net provides triage or screening services through a contracted medical/nurse advice line. Health Net members can access these services by contacting the Nurse Advice Line telephone number on the back of their ID cards.

Facility Access for the Disabled

The plan and its participating providers and practitioners do not discriminate against members who have physical disabilities. Participating providers are required to provide reasonable access for disabled members in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

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. 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
- Urgent care
- OB/GYN for preventive care, pregnancy care or gynecological complaints
- Members may be eligible to self-refer to a behavioral health practitioner, depending on their benefit coverage
- Members with chronic life-threatening, degenerative or disabling conditions or diseases that require continuing specialized medical or behavioral health care, which qualify for a standing referral to a specialist under the plan's national policy requirements. For example a member with HIV/AIDS, renal failure, or acute leukemia may seek a standing referral to a qualified, credentialed specialist
- Female members have the option of direct access to a participating women's health specialist (such as an OB/GYN or certified nurse midwife) within the network for women's routine and preventive covered health care services (such as breast exams, mammograms and Pap smears)

Missed Appointments

According to the plan's Medical Records Documentation Standards policies and procedures (KK47-121230), missed appointment follow-up and outreach efforts to reschedule must be documented in the member's record. When an appointment is missed, providers are required to attempt to contact the member a minimum of three times, via mail or phone.

Appointment Rescheduling

According to new timely access regulations (T28 CCR 1300.67.2.2) and to the plan's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly; in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice. If the applicable licensed health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered.

Advance Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow-up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers (including seldom-used or unusual specialty services) in the plan's service area, the plan 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.

Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within the plan'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, the plan 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

The plan and its participating providers must ensure that services are provided in a culturally competent manner to all members, including those who are limited-English proficient (LEP) or have limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Quality Assurance

The plan has a documented system for monitoring and evaluating provider availability and accessibility of care. At least annually, the plan monitors access to care and provider availability standards through member and provider surveys. At least quarterly, the plan reviews and evaluates the information available to the plan 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 the plan's 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 the plan regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Availability Corrective Action section below for further information.

The plan's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Health Net Medicare Plans Medical Appointment Access Standards

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments for primary care - regular and routine care (PCP)	Appointment within 10 business days of request	70%
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%
Urgent care services (SCP and other) that require prior authorization	Appointment within 96 hours of request	70%
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes	70%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and Provider After-Hours Availability Survey (PAHAS) conducted via telephone by the plan and Consumer Assessment of Health Care Providers & Systems (CAHPS®).

1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Geo-Access and Provider Availability Standards*

The plan provides established availability standards and performance goals for providers. At least annually, the plan measures, evaluates and reports geo-access and provider availability. Listed below are the plan's performance goals for geo-access and provider availability-related criteria:

Availability Standards	Performance Threshold
One PCP within 15 miles or 30 minutes from residence or workplace (each type of practitioner providing primary care)	90% or more of practitioner/provider network meet compliance rate
One SCP (including high-volume SCPs) within 15 miles or 30 minutes from residence or workplace (each type of high volume SCP)	90% or more of practitioner/provider network meet compliance rate
One BHP (including substance abuse providers and high-volume BHPs) within 15 miles or 30 minutes from residence or workplace (each type of high volume BHP)	90% or more of practitioner/provider network meet compliance rate
One hospital within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One ancillary care provider (laboratory, radiology, pharmacy) within 15 miles or 30 minutes from PCP locations	90% or more of practitioner/provider network meet compliance rate

*Certain urban, rural or suburban portions of the plan service area may have a standard that differs from within 15 miles/30 minutes based on lack of practitioner and hospital availability. Regulatory approval is required for areas that vary from within the standards.

Practitioner/Provider Availability Standards

Availability Standards	Performance Threshold
Member to FTE PCP ratio	2,000:1

Availability Standards	Performance Threshold
Member to FTE physician ratio	1,200:1
Percent PCPs open practice	85% of PCPs accepting new members
Percent SCPs open practice	85% of SCPs accepting new referrals
Member to BHP ratio MD Psychiatrists Clinical Psychologists Master's Level practitioner	 6,250:1 2,875:1 1,450:1

Corrective Action

Health Net investigates and implements corrective action when timely access to care standards, as required by Health Net's Appointment Accessibility for all lines of business appointment access policy and procedure (CA.NM.05), is not met.

Health Net uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one or more metrics are noted as being noncompliant:

- Appointment access - PPGs that do not meet Health Net's 90% rate of compliance/performance goal in one or more of the appointment access metrics.
- After-hours access - PPGs that do not meet Health Net's 90% rate of compliance/performance goal in one or more of the after-hours metrics.

PPG Notification of CAP

Health Net provides the following:

- PPGs receive a description of the identified deficiencies, the rationale for the corrective action and the contact information of the person authorized to respond to provider concerns regarding the corrective action.
- Feedback to the PPGs regarding the accessibility of primary care, specialty care and telephone services, as necessary.

CAP Minimum Requirements

- Each PPG is required to send in a written improvement plan (IP) to include what interventions will be implemented for each deficiency to improve access availability. The IP must include:
  - Date of implementation of the IP.
  - Department/person responsible for the implementation and follow-up of the IP.
  - Anticipated date that the IP is expected to produce outcomes that result in correcting the deficiency.
- The PPG is to return the IP within 30 calendar days.
- The PPG is to return the signed Provider Notification of Timely Access Results Attestation that attests that the PPG has notified their providers of their individual results and of their responsibilities of compliance related to timely access.
- Providers and PPGs deemed non-compliant will be encouraged to attend a Timely Access Training session as part of the CAP process. Health Net will notify all non-compliant providers/PPGs of the training schedule and will suggest that the provider/PPG sign up for one session. Attendance at the training will be documented. A "Timely Access Provider Training" certificate must be completed after attending the training.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to PNM and the Contracting departments for further action.

Behavioral Health Access Measurement

The Plan's access and availability policies, procedures and guidelines for providers and health care facilities providing covered behavioral health care services are in accordance with applicable federal and state regulations, contractual requirements, and accreditation standards. These access standards are based on and monitored/regulated by the Department of Managed Health Care (DMHC), the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

The Plan has a documented system for monitoring and evaluating provider availability and accessibility of care. At least annually, the Plan monitors access to care guidelines to measure behavioral health appointment access performance and confirm compliance. Participating physician groups (PPGs) are also responsible for monitoring data regarding their provider adherence to the following performance goals. Listed below are the appointment access provider criteria and performance goals for:

Medicare Advantage HMO 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

Access Measure	Standard	Performance Goal
		have access to urgent appointments within 48 hours
Non-life threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Non-urgent appointment with non-physician behavioral health care provider for routine care[3]	Appointment within 10 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care	Appointment within 96 hours of request	70%

Access Measure	Standard	Performance Goal
physician (psychiatrist) that requires prior authorization[3]		

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

For behavioral health practitioners and PPGs that offer triage and screening services, listed below are the telephone access standards.

Behavioral Health Screening and Triage Services Access Standards

Access Type	Standard/Performance Goal
Customer service - clinical referral line Average speed of answer	80% or less of all calls are answered within 30 seconds or less
Customer service - clinical referral line Abandonment rate	5% or less abandonment rate for incoming calls

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.

Provider Responsibility

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers are responsible for:

- Providing health care services to members within the scope of the provider's practice and qualifications.
- Providing care that is consistent with generally accepted standards of practice prevailing in the provider's community and the health care profession.
- Accepting members as patients on the same basis that the provider accepts other patients (non-discrimination). For additional information, refer to the Nondiscrimination topic.
- When consistent with provision of appropriate quality of care, referring members only to participating providers in compliance with the plan's written policies and procedures.
- Obtaining current insurance information from the member.
- Cooperating with the plan in connection with health plan performance of utilization management and quality improvement activities, including prior authorization of necessary services and referrals.
- Informing the member that the referral services may not be covered by the plan when referring to non-participating providers.
- Providing the plan with medical record information if requested for a member for processing application for coverage; for prior authorizing services or processing claims for benefits; or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. (the plan has a valid signed authorization from our members authorizing any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or other insurance information exchange to release information to the plan if requested. Participating providers may obtain a copy of this authorization by contacting the plan. The plan does not reimburse for the cost of retrieval, copying and furnishing of medical records).
- Cooperating with any authorized plan business associate who may need to access member records that may include payment or medical records to determine the proper application of benefits, as well as the propriety of payments (including any claims payment recovery actions performed on behalf of Health Net).
- In the event of provider termination, cooperating with the plan and other participating providers to provide or arrange for continuity of care to members undergoing an active course of treatment, subject to the requirements and limitations of California statute.
- Operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care including federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162, and 164.

Other provider rights and responsibilities are included in the Provider Participation Agreement (PPA).

Claims Denials

Participating Physician Groups (PPG) | Hospitals

The Delegation Oversight auditors review claim denial by delegated entities to ensure that notification letters to providers comply with accuracy and timeliness requirements. Providers may not send a denial notice to a member as they are provider denials only..

Claim Audit Check Cashing Requirement

Health Net conducts audits to ensure 70% of checks mailed by the delegated entity to their participating and non-participating providers are cleared within 14 calendar days from the date the check was mailed. Check mailing is monitored to validate that checks are being mailed timely.

Claims Payment Requirements

Provider Type: Participating Physician Groups (PPG) | Hospitals | Ancillary

Timely payment of claims is monitored via delegated entities' monthly timeliness report (MTR), and is verified by routine and targeted audits conducted by the Delegation Oversight staff. Delegated entities are not required to send Explanation of Benefits (EOB) to Medicare Advantage (MA) members. However, the data used for the EOBs must continue to be provided to the plan by delegated entities at the time of the Delegation Oversight Audit. Additionally, as required by Centers for Medicare and Medicaid Services (CMS), the data provided is also used by the plan to produce EOBs.

Delegated entities are required to comply with the following:

- Process 95 percent of MA clean claims from non-affiliated providers within 30 calendar days, and all other MA claims within 60 calendar days of receipt.
- Process MA provider disputes within 30 calendar days from receipt.
- The current published Centers for Medicare and Medicaid (CMS) interest rate is paid on all non-affiliated late claims.

MA claims that are not processed within the requirement thresholds are considered noncompliant with CMS regulations.

Authorization and Referral Timelines

Participating Physician Groups (PPG) | Hospitals

Hospitals Only

According to the utilization management (UM) standards - Commercial (PDF) or utilization management (UM) standards- Medicare Advantage (PDF), all hospitals are required to:

- Approve or deny and process 95 percent of all elective authorization requests within five days from the time of receipt of all clinical information
- Approve or deny and process 100 percent of all urgent requests for authorization within 24 hours
- Review 90 percent of all inpatient admissions daily
- Initiate 90 percent of all discharge planning within 24 hours of admission

For current standards, refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp to locate the Approved ICE Documents.

PPGs Only

According to the utilization management (UM) standards, all participating physician groups (PPGs) are required to:

- Approve or deny and process all routine authorization requests within the applicable regulatory time frame of the date of receipt of all information necessary to render a decision.
- If additional clinical information is required, the member and practitioner must be notified in writing within the applicable regulatory time frame of the extension.
- Communicate the decision to the member and practitioner within the applicable regulatory timeframe from the date of the original receipt of the request.
- Approve or deny and process all urgent requests for authorization within 72 hours after the receipt of the request for service.

The regulatory time frames begin when the delegated PPG's UM department receives a request for prior authorization. If the PPG's UM department receives a request for prior authorization of services and it is determined to be the plan's responsibility, the PPG must immediately forward the request to the plan as the regulatory time frames begin at the time of the original request. The commercial Informational Letter to Member or Provider/Physician carve-out letter(PDF) or Medicare Advantage Informational Letter to Member or Provider/Physician carve-out letter (PDF) serves to advise the member that the PPG's utilization management entity received a prior authorization request for which the PPG is not delegated to conduct a prior authorization review and notifies the member that the request has been forwarded to the plan. The regulatory time frame for the prior authorization review does not reset or stop when this letter is issued.

For additional information, refer to:

- Utilization Management Timeliness Standards - Medicare (PDF)
- Utilization Management Timeliness Standards - Commercial (PDF)

Prior authorization for DSNP services not covered under Medicare but covered under Medi-Cal for members in Exclusively Aligned Enrollment (EAE) counties

Dual Special Needs Plan (DSNP) contractors are required to provide integrated organization determination for the DSNP members in Exclusively Aligned Enrollment (EAE) counties. For DSNP members in EAE counties, you must review **both** Medicare and Medi-Cal benefits to determine eligibility for the service requested. Do not

deny prior authorization as “not a covered benefit” without checking both Medicare and Medi-Cal covered services (refer to the list of services below).

DSNP prior authorization timelines

PPGs should forward prior authorizations for the services that are not covered under Medicare but that are covered under Medi-Cal to Health Net within the following timelines:

- For standard requests, forward to Health Net within 1 business day upon receipt of the request.
- For expedited requests, forward to Health Net within 24 hours upon receipt of the request.

Fax authorizations to the Health Net Medi-Cal Prior Authorization Department fax number

Fax prior authorizations to the Medi-Cal fax number listed under Health Net Prior Authorization Department in the Provider Library’s Contacts section and include:

- The date and time that the service request was initially received.
- The clinical decision that was used to make the initial determination.

Services not covered under Medicare but covered under Medi-Cal

- Asthma remediation
- Community Based Adult Services
- Community Supports
- Community transition services/nursing facility transition services to a home
- Day habilitation programs
- Durable medical equipment (DME) that is covered by Medi-Cal
- Environmental accessibility adaptation (home modification)
- Housing deposit (up to $6,000)
- Housing tenancy and sustaining services
- Housing transition navigation
- Long-term care
- Medically tailored meals
- Nursing facility transition/diversion to assisted living facilities
- Personal care services and homemaker services
- Recuperative care
- Respite services
- Short-term post-hospitalization housing
- Sobering centers

Scenarios where PPGs would be responsible for sending out the Applicable Integrated Plan (AIP) Coverage Decision Letter

Refer to the below table to see the scenarios where PPGs are responsible for sending out the AIP Coverage Decision Letter. This will help PPGs determine when to forward the authorizations to the Plan and when to send the Applicable Integrated Plan Coverage Decision Letter for DSNP members in EAE counties.

Scenario	Delegated PPG	Health Plan
Eligibility denial	Deny and send AIP coverage decision letter.	N/A

Scenario	Delegated PPG	Health Plan
Medical necessity denial	Deny and send AIP coverage decision letter.	N/A

Scenarios where PPGs would be responsible for forwarding the request to the Health Plan

Scenario	Delegated PPG	Health Plan
Benefit denial	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.
Out of network	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.

The Applicable Integrated Plan Coverage Decision Letter can be found in the Delegation Oversight Interactive Tool (DOIT)/MetricStream.

Credentialing and Recredentialing

Provider Type: Hospitals

Hospitals are required to:

- Assure that the credentialing/recredentialing plan meets 100 percent of National Committee for Quality Assurance (NCQA) credentialing/recredentialing standards, and execute these activities according to that plan.
- Achieve and maintain no less than 70 percent compliance with the plan's medical records criteria for each primary care physician (PCP).
- Measure and report, as a network, data elements necessary to determine compliance with Healthcare Effectiveness Data and Information Set (HEDIS®) quality benchmarks.
- Achieve and maintain compliance with Department of Health and Human Services (HHS) standards.
- Achieve and maintain compliance with Centers for Medicare and Medicaid Services (CMS) standards.
- As applicable, maintain compliance/certification with Joint Commission on Accreditation of Healthcare Organization (JCAHO).

Health Net retains the right, based on quality issues, to terminate or suspend individual practitioners, providers, and sites, regardless of the credentialing delegation status of the PPG, IPA or entity.

Eligibility and Data Entry Requirements

Participating Physician Groups (PPG) | Hospitals

All participating physician groups (PPGs) and hospitals are required to enter the following into the PPG's or hospital's system:

- Eligibility and primary care physician (PCP) assignment information within two business days after receipt.
- New member information that is not yet on eligibility or capitation reports upon verification of eligibility.
- PCP changes requested by the member within two business days of receipt of requested change.

Quality Improvement Problem Resolution

Participating Physician Groups (PPG) | Hospitals

Under the plan's quality improvement (QI) standards, all participating physician groups (PPGs) and hospitals are required to:

- Initiate research, on quality-of-care problems identified by clinical staff.
- Provide feedback and information on the issue so that a determination can be made.
- Participate in the QI corrective action process, as applicable.

Quality Improvement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's quality improvement (QI) programs, procedures and policies.

Select any subject below:

- Disease Management Programs
- Health Education Program
- Health Management Programs
- Language Assistance Program and Cultural Competency
- Quality Improvement Program

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:

- Health and Wellness Program Disclaimer
- Health Net's Health and Wellness Program

Health Net's Health and Wellness Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net's Health and Wellness (HMO, EPO, PPO, Medicare Advantage) program provides an integrated, health management solution to improve the health and quality of life for Health Net members. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced clinical staff can assist members at-risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. The program includes a suite of services including wellness, disease management, care management and education and support tools for members.

Nurse Advice Line

Health Net's nurse advice line provides effective, appropriate and timely triage for health-related problems through experienced registered nurses and industry-approved guidelines and protocols. Nurse advice line registered nurses accurately identify member needs and ensure they are directed to the appropriate level of care for their situation -- whether it be providing self-care guidance or recommending a visit to urgent care or the emergency room. The service is offered 24 hours a day, seven days a week, 365 days a year, in English and Spanish, with translation services available for other languages. The nurse advice line phone number is listed on the back of Health Net members' identification cards.

Wellness Programs

Health Net offers members a number of wellness programs and resources through the Wellness Center on the Health Net member portal at www.healthnet.com. Members have access to the secure Health Profile, RealAge Test (health assessment) and Health Coaching through Sharecare. The Online RealAge program offers a variety of program health topics, including stress, nutrition, sleep and activity. Additional resources include online health challenges, trackers, videos and more.

Providers may refer members using the Care Management Referral form (PDF) to:

- The Craving to Quit tobacco cessation program, available to commercial members). members only).
- The Health Coaching Program (available to Commercial members only).

A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Disease Management Program

Health Net's high risk disease management program provides support to members with chronic conditions, including heart failure (HF), chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes, and asthma. Health Net disease management helps increase the efficiency and effectiveness of care, leads to more timely actions by the member, and helps develop more personalized and actionable solutions that ultimately lead to improved health outcomes. The goal of the disease management program is to support members' self-care skills, increase their self-confidence and help them work effectively with their providers to manage their health conditions. Health Net provides participants and their providers the programs, tools, connectivity, and information to make better health care decisions to:

- Slow the progression of the disease and the development of complications through proven program interventions.
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines and care plans.
- Manage medications and enhance symptom control.
- Educate members regarding recommended preventive screenings and tests in accordance with national clinical guidelines.
- Reduce emergency room visits, hospitalization and medication errors, and prevent future occurrences.

Providers may refer members using Care Management Referral form (Commercial/Medicare Advantage (PDF)). A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Care Management

Health Net's complex care management program targets members with the most complex cases including behavioral health, often those with life-limiting diagnoses, and assists members who have critical barriers to their care. Trained nurse care managers or licensed clinical social workers provide telephonic contact with Health Net members, their families and caregivers. These members often have multiple comorbid conditions and need assistance in planning, managing and executing their care.

Health Net's telephonic case management program is available to high-risk members with less complex needs. The initial assessment and subsequent outreach is conducted over the telephone and may be face-to-face contact as needed. The Case Management department will continue coordination and re-assessments until the member's needs are met and the case can be closed. Use the Health Net Care Management Referral Form (PDF) to refer members for complex case management.

Health Nets Special Needs Plan (SNP) care management (CM)- All SNP and CMC members are automatically assigned CM during the month of CMC membership enrollment with the plan and becoming eligible with Health Net (Health Net or PPG CM assigned per delegation).

Health Net and its contracted providers are responsible for coordination and delivery of all dual special needs plan patients' Medicare and Medi-Cal benefits regardless of how the member receives their Medi-Cal benefits.

Health and Wellness Program Disclaimer

Provider Type: Physicians | Participating Physician Groups (PPG)

Members have access to our wellness programs, including Sharecare, through current enrollment with Health Net of California, Inc. Our wellness programs are not part of Health Net's commercial medical benefit plans. They are not affiliated with Health Net's provider network, and their services may be revised or withdrawn without notice. These programs, including access to any clinicians, are additional resources that Health Net makes available to enrollees.

Health Education Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net encourages participating physician groups (PPGs) to provide health education and disease management programs to their members based on identified risks and Healthcare Effectiveness Data and Information Set (HEDIS®) standards.

PPGs should offer health education programs at each PPG delivery site (including satellites) with 5,000 or more Health Net members. Each PPG plans health education programs based on the recommended program criteria and protocols included in the Health Education Program subtopic.

Providing health education programs is part of the contractual agreement between Health Net and the PPG. The PPG is responsible for planning, implementing and evaluating its health education programs.

Health Education Program Offerings

All PPGs should recommend the following core topics: diabetes management, early prenatal education, baby care basics, and for Health Net Medicare Advantage (MA) members, a senior-specific health education or disease management program. Health Net encourages PPGs to provide additional program topics that reflect the breadth and depth of their members' needs. This includes efforts to identify members who smoke and to refer them to appropriate programs.

PPGs may select additional topics from the following list. PPGs are encouraged to select additional topics based on demographic and diagnostic data specific to their members.

Category	Examples
Maternal, infant and child health	VBAC, childbirth preparation, breastfeeding
Circulatory	hypertension, hypercholesterolemia
Respiratory	COPD, asthma
Musculoskeletal	back care, arthritis, osteoporosis
Weight management	adults, adolescents, children

Advisory Committee and Program Coordinator

Advisory Committee

Participating physician groups (PPGs) should designate a standing health education advisory committee, including at least one physician and the health education coordinator, to be involved in program planning, evaluation, internal communication, and promotion. This committee can be the same as the PPG Quality Improvement Committee (QIC). The health education advisory committee is responsible for:

- Meeting at least once a quarter.
- Maintaining written records of the advisory committee.

Health Net recommends that PPGs:

- Select advisory committee members to achieve a wide representation of departments in the PPG or geographic locations in a PPG.
- Distribute meeting minutes widely within the PPG so that staff are kept informed about the program.
- Develop a supportive, enthusiastic advisory committee. This helps to ensure a quality program and win support from other physicians and staff.

Health Education Coordinator

PPGs should designate a health education coordinator responsible for coordination and delivery of the health education programs, including PPG staff program orientation and record keeping.

Health education coordinators should spend the following number of hours per week coordinating the health education programs based on the PPG's Health Net membership.

PPG Membership	Hours Per Week
Fewer than 5,000 members	15
5,000 to 10,000 members	15 to 25
10,000 to 20,000 members	25 to 40
20,000 or more members	40 hours or more

The health education coordinator's responsibilities are to:

- Direct members into health education programs based on referrals from Health Net care managers or health risk assessment (HRA) results.
- Be accessible to Health Net members seeking information, suggestions and problem solving.
- Coordinate satellite programs (unless another coordinator is designated to do this).
- Maintain all program records and make them available for the site evaluation.

Health Net recommends that:

- Health education coordinators have one of the following credentials: masters of public health (MPH), certified health education specialist (CHES), registered nurse (RN), physician assistant (PA), family nurse practitioner (FNP), registered dietitian (RD), or a Masters or Bachelors degree in health education, nutrition or exercise physiology.
- Health education coordinators receive administrative and medical staff support.

Health Education Program Protocols

Health education program protocols are recommendations for success when providing classes on diabetes, early prenatal education and baby care basics. Program protocols also include disease-specific education programs and smoking cessation for participating physicians groups (PPGs).

Diabetes Education Program Protocols

All diabetes education programs should encourage an active partnership between the member, the member's family and the health care provider. Such partnerships can improve member adherence to treatment plans and enable families to better support efforts to control the member's diabetes.

It is also important that all diabetes education programs emphasize the concept of self-management of diabetes rather than teaching individual skills.

The following topics are required for all diabetes education programs:

- Understanding diabetes:
  - Basic definition and facts about diabetes
    - Normal and abnormal glucose metabolism
    - Classifications: Type I and Type II
  - Factors in the development of Type I and Type II diabetes
  - Signs and symptoms of diabetes
  - Chronic complications
    - Retinopathy
    - Neuropathy
    - Nephropathy
    - Cardiovascular disease
    - Sexual dysfunction/impotence
- Medications (as indicated):
  - Oral medication
  - Insulin use
    - Review of insulin's action
    - Injection techniques
    - Dosage
    - Insulin reaction (hypoglycemia)
    - Hyperglycemia
- Strategies to control diabetes:
  - Blood glucose monitoring and interpretation of results
  - Nutrition and meal planning
  - Exercise and activity
  - Routine tests to measure control
    - Annual retinal examination
    - Glycosylated hemoglobin (HbgA1c) screening every three months
    - Annual microalbumin creatinine urine screening
    - Blood pressure screening at every visit
    - Cholesterol screening once a year
    - Foot examination at every visit
- Living with diabetes:
  - Preventing, detecting and treating complications
    - Skin, eye and dental care
    - Immunizations
    - Infections
    - Foot and leg care
    - "Sick day" rules
    - Identification (such as MedicAlert)
  - Psychological adjustment
  - Lifestyle considerations (nutrition, physical activity and smoking cessation)
  - Family involvement
  - Community resources
- Patient self-care:
  - Behavior change strategies
  - Goal setting
  - Risk factor reduction
  - Problem-solving

Adapted from the Journal of Clinical and Applied Research and Education, Diabetes Care, American Diabetes Association, Volume 38: Supplement 1, January 2015.

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis. Health Net recommends that participating physician groups (PPGs) also offer seminars or classes at least monthly. The diabetes education program may also be a one-session class, multiple-session classes, one-to-one counseling, or any combination of these modes. The recommended minimum length for group programs is three to four sessions, each two hours in length. Classes and seminars should be followed by a one-hour, one-to-one follow-up appointment to develop individualized care plans.

Participant Tracking

PPGs should give documented feedback regarding a member's program attendance to the physician for him or her to include in the member's medical chart.

Disease-Specific Program Protocols

It is important that all disease-specific education programs encourage an active partnership between the patient, the patient's family, and the health care provider. Such partnerships can improve patient adherence to treatment plans and enable families to better support the patient's efforts to manage his or her disease.

Content may be expanded and additional components incorporated as indicated by the specific disease or condition.

All disease or condition-specific education programs should cover the following topics, as applicable:

- Understanding the disease:
  - Basic definition of the disease and affected physiological processes
  - Causes of the disease
  - Signs and symptoms of the disease
- Medications (if applicable):
  - Different types of medications
  - Purpose of medications and how they work
  - Common side-effects and coping strategies
  - Importance of medication compliance
  - Methods of maintaining compliance with the medication regimen
- Living with the disease:
  - Treatment of the disease:
    - Development of treatment/care plan
    - Routine medical visits and tests
    - Avoiding, detecting and treating complications, if applicable
- Lifestyle considerations:
  - Nutrition
  - Exercise
  - Other considerations specific to the disease
  - When to call a medical professional immediately
  - Psychosocial issues
  - Importance and role of family/caregivers
- Patient self-care:
  - Importance of patient compliance with treatment/care plan
  - Self-monitoring, as appropriate

- Behavior change strategies
- Individual goal setting

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis and should be at least one hour in length. Health Net recommends that participating physician groups (PPGs) offer seminars or classes, which are at least two hours in length, at least monthly. Programs may be offered as a combination of quarterly group programs with one-to-one counseling available in the other two months, as long as both programs are equally available to members.

Participant Tracking

PPGs should document feedback regarding a member's program attendance to be given to the physician for him or her to include in the member's medical chart.

Patient Health Education

Patient health education is the effort to keep members fully informed about the availability and use of participating physician group (PPG) facilities and services.

PPGs must offer patient health education as a covered service to members in two main areas:

- Proper use of Health Net and PPG services.
- Health maintenance and improvement, including personal health care measures and counseling.

Health Net has developed an enrollment packet, which includes a plan overview that explains to members how to use Health Net and PPG services. This enrollment packet is distributed to members, along with identification (ID) cards and the member's Schedule of Benefits. Members are directed to contact their PPGs if they have questions.

PPG Responsibilities

PPGs must make an effort to keep members fully informed about the availability and use of PPG facilities and services. New member interviews, letters of introduction and the Health Net Member Services Department provide sources of ongoing education and information.

Health education services, including educational activities and publications that contain instructions on achieving and maintaining physical and mental health and preventing illness or injury, should be developed by the PPG.

Health Net's Pre-recorded Health Information

Health Net offers a library of pre-recorded information on a variety of health topics to all Health Net members through the AudioHealth Library®. Members may access the library by contacting the Health Net Member Services Department.

Responsibilities for Health Education Programs

Program Delivery Site

Participating physician groups (PPG) and its participating providers should dedicate and maintain a physical environment or setting conducive to the delivery of health education programs and optimal learning and ensure that is appropriate for its Health Net membership. Specifically:

- Member education must not occur in an examination or a waiting room during clinic hours.
- All programs should be conducted onsite or at an appropriate offsite location.
- The sites must be accessible to individuals who have physical limitations.

Program Evaluation and Tracking

Health Net recommends that groups evaluate all classes and seminars using a written participant evaluation form. The evaluation form should include an overall satisfaction question using a five-point rating scale, such as:

5	4	3	2	1
Extremely Satisfied	Very Satisfied	Satisfied	Not Very Satisfied	Extremely Dissatisfied

Written participant evaluation forms are not required for one-to-one counseling sessions.

PPGs should conduct follow-up telephone calls or use other means to evaluate the quality of one-to-one counseling sessions.

Program Promotion

PPGs should promote all programs to Health Net members and PPG staff. Health Net encourages PPGs to mail promotional materials to Health Net members at least once per year to promote all health education programs. Suggested promotional activities include:

- Flyers and posters in waiting areas.
- Medical group newsletters via direct mail.
- Telephone recordings.

PPGs may not use the Health Net corporate logo on material without Health Net's permission.

Record-keeping Responsibilities

PPGs should use and maintain appropriate medical and non-medical records (for example, attendance lists, evaluation forms, patient education sign-in sheets, and documentation of feedback to physicians).

Specifically, PPGs should maintain the following documentation:

- Attendance records or one-to-one education sign-in sheets identifying Health Net members.
- Written program evaluations for all programs (except one-on-one counseling).
- A system to document smoker identification and referrals to a smoking cessation program.

- Minutes from advisory committee meetings.
- A physician feedback system of participant attendance and progress in the diabetes and early prenatal programs, which provides a link between the referring physician, patient, and health education program:
  - Attendance feedback is documented in the member's medical record or in a central file.
  - A random sampling of medical records or copies of feedback records may be reviewed during the annual site evaluation.

  PPGs may also document the member's progress, response to education and attendance in other programs and share this information with the member's physician.

Speakers Bureau

Participation in Health Net's Speakers Bureau program is optional. Participating physician groups (PPGs) are asked periodically to provide presentations or screenings to Health Net employer groups.

For more information, select any subject below:

- Smoking Cessation Program

Smoking Cessation Program

Provider Type: Physicians | Participating Physician Groups (PPG)

Participating physician groups (PPGs) can implement an ongoing, systematic process for identifying members who smoke. Members may be referred to programs offered by the PPG or the Craving to Quit program.

Craving to Quit Program[1]

Sharecare is a vendor that provides an enhanced wellness program to members. Sharecare's tobacco cessation program is designed to help users who are ready to quit to permanently break their addiction to tobacco. Participants will utilize a digital support approach that provides mobile and online tools, resources and messaging features with trained experts.

Craving to Quit is an evidence-based 21-day smoking and vaping cessation program delivering treatment via app or website. The program helps retrain the brain using mindfulness to break the habit loop.

In the United States, 70 percent of smokers want to quit smoking, but only 10 percent will do so successfully on their own. This program’s tools and learning modules can maximize your odds of successfully quitting. Some of the tools available include:

- Daily tracking
- Daily coaching
- Daily nudges
- An online community

- A quitting pact
- 40 additional optional modules
- Mindfulness tools

Enrollment in the tobacco cessation program is initiated by Eligible Users who are ready to quit smoking.

The digital service option provides up to twelve (12) months of unlimited support for eligible participants.

Refer members other than Medicare members to the Craving to Quit telephonic tobacco cessation program to speak to an enrollment specialist.

[1]Craving to Quit is not offered for Health Net Medicare members.

Other Tobacco Cessation Resources

Kick It California (formerly California Smoker's Helpline) is a tobacco cessation program available to Health Net members. The program offers specialized services for teens, pregnant smokers, individuals who chew tobacco, and e-cigarette users, and extends information on how to help a friend or family member quit tobacco use. Telephonic coaching is available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese) and text programs may be obtained in English or Spanish. Members can learn more by calling Kick It California at 800-300-8086 or online at www.kickitca.org.

Recommendations

Providers should assess and document smoking status as part of the vital signs he or she collects at each clinical visit for every member. Adding smoking status to the vital signs assessment, an activity usually completed by a nurse or medical assistant prior to the physician's encounter, ensures that all smokers are identified.

Nicotine Replacement Therapy

Health Net is responsible for the approval of nicotine replacement therapy (NRT) for prescription-only and other smoking cessation products for members who have smoking cessation benefits. If applicable, providers can complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) (for approval of NRT), indicating that the member is using it for smoking cessation and is enrolled in a smoking cessation program.

Health Management Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains information on Health Net's health management programs.

Select any subject below:

- Overview
- Adult Depression Program
- Breast Cancer Health Initiative
- Health Net's Health and Wellness Program
- Senior Health Promotion Survey

Overview

Provider Type: Participating Physician Groups (PPG)

Health Net has developed innovative health management programs to measure and improve the health status and quality of life of members through collaborative relationships with employers, purchasing coalitions and participating physician groups (PPGs).

Management of Osteoporotic Fractures

The primary objective of the Osteoporosis Initiative is to improve the quality of care for post-menopausal women with osteoporotic fractures. Members who have not had a bone mineral density (BMD) test or an appropriate medication for osteoporosis treatment after a fracture are identified for intervention.

Member Satisfaction Survey

Member satisfaction with the quality of care and services rendered by Health Net, participating physician groups (PPGs) and physician offices is measured at least annually. Health Net participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Satisfaction Survey. CAHPS® assesses the level of member satisfaction with components of health care delivery such as access to care (routine, urgent and specialty care), wait time in the provider office, medical services, and overall member satisfaction.

Behavioral Health Services

Provider Type: Participating Physician Groups (PPG)

Health Net has quality initiatives to improve members' physical and mental health outcomes. Health Net focuses on various psychotropic medications, including antidepressant medication management. For example, eligible members with gaps in their antidepressant medication refills, and who are diagnosed with depression, receive automated or live outreach conducted by clinical pharmacists to remind them to continue taking their medications, refill their prescriptions and report any medication problems or concerns to their providers.

Most Health Net members appropriately seek depression treatment from their primary care physicians (PCPs), which is why Health Net provides physicians and participating physician groups (PPGs) with tools, such as

Provider Tip Sheets, to support the management and coordination of care for members diagnosed with behavioral health conditions.

In an effort to increase awareness of the importance of identification and management of behavioral health conditions, among both providers and members, Health Net has been developing and posting:

1. Member online news articles to educate members on behavioral health (i.e., mental health and substance use), how to recognize the need for help, the availability and types of treatments, and the importance of treatment, medication adherence, and communicating with their providers.
2. Provider online news articles on the importance of monitoring, managing, and coordinating care and information exchange between medical and behavioral health providers, and available resources for easy reference and assistance.

Breast Cancer Health Initiative

Provider Type: Physicians | Participating Physician Groups (PPG)

The Breast Cancer Health Initiative is targeted toward members ages 40 through 74. Members in this age range should have mammography screenings. Health Net may place telephone calls, contract with a vendor to conduct either live or automated calls, send email, and text or mail reminders to members who have not had a mammogram in the past two years since turning age 40 to encourage them to complete the breast cancer screenings recommended for their age group. Health Net may also reach out to members eligible for the breast cancer screening measure (compliant or non-compliant) and survey them on what helped and could help keep them up with their care, in order to plan and strategize future interventions to better address members' needs. The effectiveness of these interventions is measured through the Healthcare Effectiveness Data and Information Set (HEDIS®) Breast Cancer Screening measure.

Health Net’s Health and Wellness Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net’s member wellness portal is a central hub for all of the wellness programs and activities. The wellness programs were created to engage people in their health with personalized tools and achievable goals. Members can feel confident in their ability to make positive and lasting behavioral changes.

Senior Health Promotion Survey

Provider Type: Participating Physician Groups (PPG)

A health promotion survey of Medicare members has been in use plan-wide since 1995. The survey collects information about medical conditions, behavioral risk factors, health care utilization, and social support systems from newly enrolled Medicare members. The Senior Health Promotion Survey also identifies high-risk seniors, allows for the development of baseline assessments, and provides the physician and Health Net care managers with medical profiles. Physicians receive individual profiles of Health Net Medicare Advantage (MA) members to determine which members may require intervention.

Refer to the Health Promotion Survey in the Utilization Management topic under Care Management for additional information. A sample of the Health Net MA health questionnaire is available.

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

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Federal and state laws require that providers ensure all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency (LEP), limited reading skills, who are deaf or who have hearing impairment, disability, or have diverse cultural and ethnic backgrounds. To assist in meeting these requirements, Health Net offers interpreter support and encourages providers to consider 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. OMH also has a no-cost, accredited maternal health care training available at Think Cultural Health.

The Institute for Healthcare Improvement has free downloads to improve plain language communication with patients under the Ask Me 3® program.

Health Net does not sponsor the trainings or materials. However, the Health Equity Department can customize cultural competency training to meet your needs.Health Net participating providers must comply with the following requirements. Care plans must be written at an 8th grade reading level. Health Net provides the

translations in threshold languages upon request with documentation that the content is at an 8th grade reading level.

Linguistic Services Requirements

Participating providers are responsible for providing interpreters at no cost to members who require or request them. Participating providers must:

- 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.
- Use taglines and nondiscrimination notices (PDF) in correspondence sent to the member on Health Net's behalf that advise members that they can receive an interpreter in their preferred language at medical points of contact.
- 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 others.
- Providers may not request or require an individual with LEP to provide his or her 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.

Interpreter Support

Health Net provides interpreter support for members with LEP at all medical points of contact.

Providers may also request in-person interpreters for clinical visits. Health Net recommends five days advance notice for in-person interpreters and 10 days for sign language interpreters. 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. Refer to the provider Interpreter Services Flyer (PDF) for assistance.

A Language Identification Poster (PDF) is available to print and post in providers' offices.

For more information about how to work with an interpreter, refer to the Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF).

Cultural Competency Training

All providers are encouraged to participate in a cultural competency training course as part of their continuing education. HHS OMH offers a computer-based training program on cultural competency for health care providers at no cost. This program was developed to furnish providers with competencies enabling them to better treat the increasingly diverse population. Additionally, the OMH training offers continuing medical education (CME) units. For more information, refer to OMH Think Cultural Health. OMH also has a no-cost, accredited maternal health care training available at Think Cultural Health Education.

The Institute for Healthcare Improvement has free downloads to improve plain language communication with patients under the Ask Me 3® program.

Providers are encouraged to send their cultural competency certificate when requested by Health Net.

Providers who would like information about topics such as cross-cultural communication, health literacy or accessing interpreter services may contact Health Net's Health Equity Department.

Quality Improvement Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on the Health Net Quality Improvement (QI) program.

Select any subject below:

- Overview
- Health Net Quality Improvement Committees
- Monitoring Access Standards Compliance
- Quality Improvement HAC Program
- Quality Improvement Program
- Quality Improvement Program and Compliance and HEDIS
- Quality of Care Issues

Overview - Quality Improvement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement (QI) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals.

Health Net’s Population Health Management strategy provides usage risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social determinants of health (needs at all stages of life. The QI program impacts the following:

1. **Health Net members** in all demographic groups and in all service areas in which Health Net is licensed.
2. **Network Providers**, including physicians, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
3. **Aspects of Care**, including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.
4. **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
5. **Communication** to meet the cultural and linguistic needs of all members.
6. **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
7. **Provider/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
8. **Services Covered by Health Net**, including preventive care; primary care; specialty care; telehealth, ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing care; home health care; long term care (LTC), Long-Term Services and Supports (LTSS): Community Based Adult Services (CBAS) which meets the special, cultural and linguistic, complex or chronic needs of all members.
9. **Internal Administrative Processes** which are related to service and quality of care, including customer service, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

Except for Molina, Health Net does not delegate its QI program or oversight responsibilities to PPGs, participating providers, hospitals, or ancillary providers. PPGs, participating providers, hospitals, and ancillary providers are required to comply with the standards and requirements set forth by Health Net, included in this operations manual.

Health Net regularly communicates information about Health Net's QI program goals, processes and outcomes as they relate to member care through provider updates, committee meetings and other forums. QI program information is also available to providers by request through Health Net's Provider Services Center (Commercial, Medicare Advantage, Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley).

Health Net Quality Improvement Committees

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement Committee (HNQIC) is responsible for oversight of the Quality Improvement (QI) program and monitoring the quality and safety of care and services rendered to Health Net members.

The HNQIC structure ensures providers participate in the planning, design, implementation, and review of the QI program. External providers participate on the HNQIC along with representatives from MHN (Health Net's behavioral health division), the pharmacy department, Provider Network Management, Customer Service Operations, and Medical Management, including credentialing, peer review and utilization management.

HNQIC functions include the following:

- Review and approval of the annual QI and UM program description, work plan and evaluation.
- Reporting to the board of directors or executive management team at least annually.
- Ensuring external practitioner participation in the QI program through planning, design, implementation or review.
- Recommending policy decisions, evaluating the results of QI activities, instituting needed actions, and ensuring follow-up, as appropriate.
- Reviewing behavioral health care initiatives and outcomes.
- Analyzing and evaluating the results of focused audits, studies, quality of care, safety issues, and quality of service issues.
- Monitoring for compliance and other QI findings that identify trends and opportunities for improvement.
- Providing input and recommendations for corrective actions and monitoring previously identified opportunities for improvement.
- Overseeing the CMS QI program and receiving periodic reports on CMS-required QI activities.
- Overseeing the state and federal regulatory QI Program requirements by reviewing reports on required QI activities.
- Providing support and guidance to health plan associates on QI priorities and projects.
- Monitoring data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
- Addressing utilization management and QI activities which affect implementation and effectiveness of the QI program and interventions.

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 HNQIC 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 HNQIC 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 HNQIC.

Specialty Network Committee

Does not apply to Dual Special Needs Plan members.

The Specialty Network Committee sets standards for the Health Net participating bariatric performance centers, coordinates with the Centene Corporate Transplant Program regarding quality outcomes for contracted transplant centers, guides members to specialty network providers, monitors performance, and issues requests for CAPs. This committee meets quarterly, with ad hoc meetings scheduled as necessary, and reports annually to HNQIC.

Clinical Quality Improvement Workgroup

The QI Clinical and Service Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The Clinical QI Workgroup also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety, access to

care, services, and member and provider satisfaction. The Clinical QI Workgroup consists of a core group of QI associates, a consulting physician and ad hoc members pertinent to the report topic. At each meeting, there is focused discussion on report findings, barriers, and interventions for the purpose of making and implementing decisions regarding QI activities. The Clinical QI Workgroup meets at least four times per year and reports significant findings to the HNQIC.

Monitoring Access Standards Compliance

Provider Type: Participating Physician Groups (PPG)

Health Net measures participating physician group (PPG) performance with timely access standards through the Provider Appointment Access survey and the Provider After-Hours Access survey. Overall member satisfaction is measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey process.

Providers not meeting these standards are required to submit and follow a corrective action plan (CAP), which the Quality Improvement (QI) Department monitors. Refer to the Service and Quality Requirements discussion under the Provider Oversight topic for detailed information on access standards.

Health Net identifies a random representative sample of members each year and engages with an independent quality assurance entity to conduct interviews, using a semi-structured interview tool provided by the Department of Health Care Services (DHCS), with each member in the sample to:

- Determine background and causes for emergency room visits, including the use or failure of long-term services and supports (LTSS) or if there was a lack of appropriate LTSS to adequately support the member in his or her environment
- Determine whether the member experienced any barriers to accessing health care and understand the nature of those barriers, including, but not limited to, inadequate access to language support services, alternative format materials, and physical accessibility for disabled members

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 HAC Program

Provider Type: Hospitals

Health Net's Quality Improvement (QI) Hospital-Acquired Condition (HAC) program is designed to monitor patient care and to encourage quality improvement efforts in hospitals. The QI HAC program assesses member claims data to identify potential HACs; conducts outreach to hospitals to request details about each case; and follows up with further investigation through Potential Quality Issue referrals when appropriate. In the event that problems are identified, Health Net requests that hospitals assess their programs so that protocols can be revised to prevent such events in the future. The program is informed by guidance from CMS and The Leapfrog

Group, which represents purchasers and employer groups, to help ensure that evidence-based protocols are followed for all members to ensure safe patient care. Refer to hospital-acquired conditions for more information on the HAC process and billing.

Quality Improvement Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's Quality Improvement (QI) program provides the infrastructure for all managed care products. The QI program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes and member and provider satisfaction. The purpose and goals of the QI program are to:

- Establish standards for both the quality and safety of clinical care and service, as well as monitor and evaluate the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.
- Support Health Net's strategic business plan to promote safe, 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 an annual quality improvement work 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 Health Net QI program includes a written program description and an annually revised QI work 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 Committee (HNQIC), Health Net Community Solutions (HNCS) UM/QI Committee, and the Health Net board of directors approves and monitors the annual Health Net QI program and the QI work plan. The board of directors receives quarterly reports regarding medical affairs, QI, utilization management (UM), and pharmacy.

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. 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:

- Overview
- Direct Network Referral Process
- Investigational and Experimental Treatment
- OB/GYN Self-Referrals
- Out-of-Network Referrals
- Post-Stabilization Care
- Role of the Primary Care Physician
- Self-Referral Benefits

Overview

Participating Physician Groups (PPG)

Participating physician groups (PPGs) are responsible for providing or coordinating all professional services to members, including care among participating and nonparticipating providers. A referral is required for care that is beyond the primary care physician's (PCP's) or the PPG's scope of practice.

Listed below are examples of services that are referred for specialty consultation. This list provides guidelines and is not intended to be all-inclusive or indicate specific benefit coverage.

1. Cardiology - Complicated hypertension (failure to respond or adverse response to conventional therapy).
2. Endocrinology - Diabetic complications including retinopathy and nephropathy.
3. Gastroenterology - Polyps or other abnormalities.
4. Behavioral health services - Diagnosis, treatment and consultation regarding management of clearly emotional issues for which the member or PCP feels the need for consultation (behavioral health services should be coordinated with medical services).
5. Neurology - Seizures that are recurrent or refractory to treatment.
6. Rheumatology - Collagen vascular diseases depending on the extent and severity of manifestations or complications.
7. Pulmonology - Percutaneous lung biopsies.
8. Urology/Nephrology - Prostate suspicious for malignancy or obstructive symptoms that may lead to surgical treatment.
9. Infectious disease - Diagnosis, treatment and consultation regarding AIDS or human immunodeficiency virus (HIV).

The Centers for Medicare & Medicaid Services (CMS) requires the PPG to do the following when making a referral:

1. Transmit necessary information to the provider receiving the referral and vice versa.
2. Request information from other treating providers as necessary to provide care.
3. Transfer a member's complete medical records to a new provider in a timely manner (when the member chooses a new PCP with the network).

For additional information regarding prior authorizations, refer to the Prior Authorizations topic. For additional information regarding medical records, refer to the Medical Records topic.

Direct Network Referral Process

Provider Type: Physicians | Ancillary | Hospitals

Primary care physicians (PCPs) are responsible for coordinating member care and initiating specialty services. PCPs may refer a member directly to a participating specialist for specialty consultation, in-office services and selected outpatient services that do not require prior authorization.

Investigational and Experimental Treatment

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

All participating providers must immediately inform Health Net when there is a request for investigational or experimental treatment. All pertinent documentation for investigational or experimental treatments must be sent to the Health Net Medical Management Department by fax or mail.

In accordance with standards established by the Department of Managed Health Care (DMHC), Health Net has five business days to respond to member requests for review of investigational or experimental treatment. Health Net is required to review all requests for these procedures and is responsible for issuing the denial letter if the treatment is denied.

Health Net's denial letter states the medical and, if applicable, scientific reasons for the denial and any alternative treatment that Health Net does cover. The denial letter also includes an application and instructions for the member to utilize the DMHC Independent Medical Review (IMR) Program.

Participating providers should not direct members to contact Health Net for approval of these services. It is the requesting provider's responsibility to provide all pertinent information and documentation directly to Health Net.

Experimental medical and surgical procedures, equipment and medications, are not covered by Original Medicare or under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community.

DMHC Notices of Translation Assistance, Forms and Applications

DMHC Notices of Translation Assistance

Participating providers are required to insert a notice of translation assistance when corresponding with applicable members. DMHC Health Net-specific notices of translation assistance are available on the Health Industry and Collaboration Effort (ICE) website at www.ICEforhealth.org > Library > Approved ICE Documents > Cultural and Linguistic Services. For additional information, providers can contact Health Net Cultural and Linguistic Services Department.

Translated DMHC Complaint (Grievance) Forms

Physicians and ancillary providers must know how to locate and provide translated DMHC complaint (grievance) forms to members upon request. These forms are available in English, Chinese and Spanish and other languages on the DMHC website at www.dmhc.ca.gov located under File a Complaint.

Translated DMHC IMR Applications

Physicians and ancillary providers must know how to locate and provide translated DMHC IMR applications to members upon request. This application is available in English, Chinese and Spanish on the DMHC website at www.dmhc.ca.gov and search for IMR applications.

OB/GYN Self-Referrals

Provider Type: Physicians | Participating Physician Groups (PPG)

PPG Information

Health Net members have the right to self-refer for a screening mammography. In addition, members have direct access to participating women's health specialists for routine and preventive health care services provided as basic benefits.

If a member needs OB/GYN preventive care, is pregnant or has a gynecological concern, she may self-refer to an OB/GYN or family practice physician who provides such services within the member's participating physician group (PPG). If these services are not available within the PPG, the member may go to one of the PPG's referred physicians who provide OB/GYN services. Each PPG must be able to assist members by maintaining a list of its referral physicians. The OB/GYN consults with the member's PCP regarding the member's condition, treatment and any need for follow-up care.

Physician Information

A female member may obtain obstetrician and gynecologist (OB/GYN) services without first contacting her primary care physician (PCP). If the member needs OB/GYN preventive care, is pregnant or has a gynecological concern, she may self-refer to an OB/GYN or family practice physician who provides such services within Health Net's participating provider network.

If these services are not available within Health Net's participating provider network, Health Net authorizes services to a qualified non-participating provider of OB/GYN services in accordance with the Health Net prior authorization procedures.

The OB/GYN consults with the member's PCP regarding the member's condition, treatment and any need for follow-up care.

Out-of-Network Referrals

Provider Type: Participating Physician Groups (PPG)

A participating physician group (PPG) must refer members to participating providers except in emergencies or as otherwise required by law. PPGs are to use the following process when referring members to an out-of-network provider:

- Determine whether an out-of-network referral is necessary and request prior authorization.
- Have the PPG coordinator make an appointment for referral. When Health Net authorizes the referral request, the PPG coordinator arranges an appointment with the referred physician or specialist. When arrangements have been completed for the member's referral, the PPG coordinator makes a notation in the member's medical chart and completes the approrpriate form below:
    - Inpatient California Health Net Commercial Prior Authorization (PDF)
    - Outpatient California Health Net Commercial Prior Authorization (PDF)
    - Inpatient California Health Net Medicare Authorization (PDF)
    - Outpatient California Health Net Medicare Authorization (PDF)

- Enter all pertinent information and obtaining all required signatures. Verify that the referral services are covered by the member's plan, as, once Health Net authorizes a referral, the authorization cannot be withdrawn and payment is required for services rendered.
- Inform member of copayments before services are performed. Some referral services require copayments. If the PPG fails to notify the member of a required copayment before the services are performed, no copayment can be charged.
- Specify what services are being authorized. The PPG physician must specify at the time of the referral what services or treatments are being requested. Some PPGs find it useful to have the participating physician initially request an evaluation or consultation. After the results are returned, a treatment plan is reviewed and an extension of the authorization is requested.
- Confirm referral services. Before referral services are performed, the referred physician must be aware that authorization is necessary for payment by the PPG. Health Net suggests that the PPG develop a standard letter to accompany the referral, explaining to the referred physician that only authorized services are reimbursed and that a member may not be charged for services.
- Make a member aware of what services are being authorized and any limitations to the authorization. No reimbursement is provided for unauthorized follow-up visits.
- Report member encounter information relating to referral services.
- Provide assistance during the process to member as needed. The member cannot be expected to know all the steps in the referral process; the PPG must provide this information.

The PPG must inform referred physicians that they may not refer the member to, or otherwise obtain the services of, another physician or medical professional without authorization from the PPG.

Post-Stabilization Care

Provider Type: Participating Physician Groups (PPG)

A participating physician group (PPG) must immediately contact or refer requests regarding authorization for post-stabilization services to the Health Net Hospital Notification Unit.

Role of the Primary Care Physician

Provider Type: Physicians

The primary care physician (PCP) is responsible for providing comprehensive first contact and continuing care for their patients and supervising preventive, acute and chronic health care for those patients. This responsibility includes coordinating referrals to specialists, inpatient and skilled facilities, home health care, and similar services. Generally, PCPs are expected to understand and coordinate the total course of their patients' care. The PCP must also take into consideration input from the member regarding proposed treatment plans. In this way, the PCP serves a critical role in helping their patient obtain the highest coverage levels available under the HMO benefit program.

The PCP must maintain medical records, including records on preventive care, past medical treatment, past and current health status, and treatment plans for the future in the patient's medical record. When initiating a

referral to a specialist, it is the responsibility of the referring physician to forward all pertinent information to the specialist for the referral. In order to promote continuity of care, the PCP must also have on record all treatment, examination and results performed by other physicians or clinicians, including service dates. Summaries are acceptable in lieu of complete chart notes.

Self-Referral Benefits

Provider Type: Physicians

Members may self-refer to a specialist for the following services (subject to benefit limitations):

- Annual well-woman examination
- Obstetrical care
- Behavioral health care (members contact MHN, Health Net's behavioral health division)
- Substance abuse services (members contact MHN)
- Mammograms
- Routine vision examination (if plan includes a vision rider)
- Annual diabetic retinal examination
- Routine hearing examination (excluding Medicare-covered services)
- Annual influenza and pneumococcal vaccine
- Women's routine and preventive services. Health Net arranges for specialty care outside the network when participating providers are unavailable or inadequate to meet the member's medical needs

These self-referral benefits are available with the following limitations:

- Members must use Medicare Advantage (MA) participating and credentialed physicians or clinicians
- Members must receive services from a Health Net participating provider; further, members assigned to a delegated participating physician group (PPG) must receive services from physicians affiliated with the PPG

Third-Party Liability

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on third-party liability responsibilities.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

If a subscriber or member is injured through an act or omission of another person, the participating provider must provide benefits in accordance with the Evidence of Coverage (EOC) or Certificate of Insurance (COI). If the injured member is entitled to recovery, the plan and the participating provider rendering services to the member are entitled to recover and retain the value of the services provided from any amounts received by the member from third-party sources.

When the plan pays a claim with an injury or trauma diagnosis code that may be related to a motor vehicle accident, employment or possible other third-party liability, the plan may use an outside vendor, the Rawlings Company, to investigate for determination of other coverage liability. Rawlings' expertise and automated system capabilities are used to identify claims where a third party may be responsible for payment. Rawlings may directly correspond with providers requesting refunds when another liability coverage is determined to be primary. If a provider receives a refund request letter from the Rawlings Company that includes the primary coverage insurance information in the event that the provider has not already been provided the other coverage information by the member or billed the primary carrier, the provider is expected to bill the other coverage and refund the plan, via the Rawlings Company, within a reasonable time period. Failure to comply with timely filing guidelines when overpayment situations are the result of another carrier being responsible does not release the participating provider from liability.

Reimbursement to the plan or the participating provider under this lien is based on the value of the services the member receives and the costs of perfecting the lien. The value of the services depends on how the participating provider was paid and the lien amount is determined as permitted by law. Unless the money that the member receives comes from a workers' compensation claim, the following applies:

- The amount of the reimbursement that the member owes the plan or the participating provider is reduced by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines that the member was responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be the lesser of a *pro rata* reduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

Provider and Member and Responsibilities

Provider Responsibility

The participating provider must question the member for possible third-party liability (TPL) in injury cases. Often, the member does not mention that this liability exists, having received complete care without charge from the participating provider and may not feel that it is necessary. The participating provider must check for this liability where treatment is being provided. The participating provider must develop procedures to identify

these TPL cases. After TPL has been established, the participating provider must provide the plan with the information using the Authorization to Treat a Member form or other correspondence.

Submit Itemized Charges and Member's Statement of Liability for Reimbursement

When the participating provider seeks reimbursement from the third-party payer, it must do so by filing an appropriate lien. This may be done by submitting an itemized statement for paid claims or value of services rendered, whichever is appropriate, and a member's statement of third-party liability to any person or entity which may receive payments made in a settlement or judgment in the TPL case.

Lien Coordination

The participating provider must coordinate with any participating providers that assert a lien and ensure that all communication received by the member in this regard is consistent. In the event that the PPG is assigned recovery of a hospital lien, the plan must be advised promptly.

Calculation of Lien Amount

The participating providers' staff is responsible for remaining current on legal developments regarding TPL recoveries. In determining the amount of the lien, follow guidelines prepared by counsel. Recoveries for coordination of benefits (COB), duplicate payments and the like should be reconciled promptly. Where the participating provider asserts the contractual lien based on Evidence of Coverage (EOC) or Certificate of Insurance (COI), it is subject to:

- A reduction by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines the member is responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be lesser of a pro ratareduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

It is the participating provider's responsibility to act reasonably in pursuing a lien.

Member Responsibility

An injured member entitled to recovery is required to:

- Inform the plan and participating providers of the name and address of the third party, if known, the name and address of the member's attorney, if using an attorney, and describe how the injuries were caused.
- Complete any paperwork that the plan or the participating providers may reasonably require to assist in enforcing the lien.

- Promptly respond to inquiries from lien holders about the status of the case and any settlement discussions.
- Notify lien holders immediately upon the member or the member's attorney receiving any money from third parties or their insurance companies.
- Hold any money that the member or the member's attorney receives from third parties or their insurance companies in trust, and reimburse the plan and the participating providers for the amount of the lien as soon as the member is paid by the third party.

Urgent Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Urgent care services are subject to the applicable county's member copayment. The plan follows Medicare guidelines for urgent care services and all benefit determinations unless the member's Evidence of Coverage (EOC) explicitly states otherwise.

Definition of Urgent Care

In accordance with federal guidelines, urgent care is defined as:

- Services provided when a member is temporarily absent from the plan's service area or, under unusual and extraordinary circumstances, provided when the member is in the service area, but the organization's provider network is temporarily unavailable or inaccessible.
- Covered services that are not defined as emergency but are medically necessary and immediately required as a result of an unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, for the member to wait to obtain the needed services through the plan's provider network after the member returns to the service area or the network becomes available.

Access to Urgent and Emergency Care

When possible, urgent and emergency care must be provided by the primary care physician (PCP), the on-call designee, or contracting urgent care center. The member must be transferred to an urgent care center or hospital emergency room if medically necessary. The PCP or on-call physician designee is required to be available 24 hours a day, seven days a week. When the member is outside the service area and cannot obtain care from a network provider, the plan covers urgent and emergency care rendered by any provider at the listed urgent care copayment and emergency copayment.

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
- Affirmative Statement About Incentives
- Availability of Criteria
- Care Management
- Clinical Criteria for Medical Management Decision Making
- Continuity of Care
- Coverage Determination
- Health Risk Assessment
- Medical Data Management Reporting
- Medical Data Management System
- Medicare Certified Facilities
- Non-Delegated Medical Management
- Notification of Hospital Admissions
- Notification of Hospital Discharge Appeal Rights
- Out-of-Area Services
- Separation of Medical Decisions and Financial Concerns
- Termination of Provider Services
- Utilization Management Goal
- Utilization Management Program Components

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.

Affirmative Statement About Incentives

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net affirms that utilization management decision making is based on appropriateness of care and service, and the existence of coverage. Health Net does not reward practitioners or other individuals for issuing denials of service or care. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Availability of Criteria

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management Department. Providers have the opportunity to discuss any adverse decisions with the Health Net physician or other appropriate reviewer at the time of an adverse determination. The provider may also contact the medical director. A care manager may also coordinate communication between the medical director and the requesting provider.

Care Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on care management.

Select any subject below:

- Overview
- Program Description
- Care Management at PPG
- Medicare Advantage (HMO) SNP CMS Requirements
- Palliative Care Services
- Targeting and Clinical Data Analysis

Overview

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net's care management program is available to all members to:

- Create a comprehensive system of medical management,
- Use resources and managed health care expertise collaboratively, and
- Provide a full complement of coordinated cost-effective care.

The Health Net care management program provides individualized assistance to members experiencing complex, acute or catastrophic illnesses. The focus is on early identification of and engagement with high-risk members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs and improve health and functional status, resulting in favorable outcomes.

Health Net's care management program uses qualified nurses, social workers and medical directors to provide a fully integrated network of programs and services for the management of high-risk, chronic and catastrophically ill or injured individuals.

High and moderate risk Special Needs Plans (SNPs) members who are actively engaged are managed by the health plan's case manager in order to implement their individual care plan which is designed to support the member's optimal level of wellness.

Program Goals

The Health Net care management program goals are to achieve, in collaboration with providers, the following:

- **Quality health outcomes** - Identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.
- **Cost effectiveness** - Health Net is committed to measuring the effectiveness of the care management program. Additionally, with timely and accurate encounter reporting from participating physician groups (PPGs), Health Net can provide clinical and cost information feedback to PPGs to assist them in enhancing the performance of their medical management and disease-state management programs.
- **Resource efficiency** - The Health Net care management team works with internal and external stakeholders to develop outcome studies and educational programs to improve the efficiency and effectiveness of Health Net's and the PPG's care management activities.

Program Description

Provider Type: Participating Physician Groups (PPG)

The Health Net care management program integrates the care management process, eliminates duplication of services between Health Net and its participating physician groups (PPGs), and facilitates communication and cooperation between Health Net, PPGs and members.

Health Net case managers, or delegated PPGs, assure that potential medically catastrophic cases are managed in cooperation with the member's primary care physician (PCP) to achieve optimum care and coverage benefits for the member. Case managers provide assistance by working with members, caregivers, physicians, and other members of the care team.

The following criteria are used for case management:

1. Lack of an established or ineffective treatment plan – for example, a member with multiple providers and multiple services who continues to use the emergency room or continues to have multiple admissions for the same conditions.
2. Over-, under- or inappropriate utilization of services – for example, a member who inappropriately over-utilizes emergency room services, or who does not have an established PCP or specialty care provider, when appropriate.

3. Permanent or temporary alteration of functional status – for example, a member with a hip replacement who is discharged with no home support or is unable to get to medical appointments and/or physical therapy.
4. Medical/psychosocial/functional complications – for example, an elderly member with multiple medical conditions (comorbidity) and depression who is unable to manage activities of daily living, medications and diet.
5. Barriers to receiving appropriate care within the system – for example, a newly diagnosed cancer patient who has been educated by coaches, but who would also benefit from coordination of care services through Health Net's case management.
6. Nonadherence to treatment or medication regimens, or missed appointments – for example, a member with transportation needs who is unable to get to physician appointments, or who has transportation or financial barriers to filling medication prescriptions.
7. Compromised patient safety – for example, an elderly member, post hip replacement, who lives on the second floor requires home evaluation for safety concerns.
8. High-cost injury or illness – for example, a member in a severe motor vehicle accident with multiple injuries would require coordination of and authorization for multiple services for an extended period of time.
9. Lack of family or social support – for example, a post-operative member with wound care, but without family support to assist with dressing needs.
10. Lack of financial resources to meet health needs – for example, a member requiring extensive wound vacuum services but who has exhausted benefits, or a senior member who needs transportation, home help or other noncovered items.
11. Exhaustion of benefits – for example, a member with medical necessity for a specialized hospital bed, but the member's durable medical equipment (DME) benefit is exhausted.

Health Net case management functions operate according to Case Management Society of America standards.

Assessment

Assessment is the first step in the care management process. The Health Net care management team gathers information to assess the member's care gaps and needs. Information may include health risk assessment results, medical records and interviews with the member and health care team. The care manager utilizes the results of the assessment to develop a care management plan in collaboration with the member, or their designated representative, to address care needs. For additional information, refer to Case Management at PPG > Initial Assessment and Ongoing Management.

Evaluation and Monitoring

The care management process continually evaluates quality of care, efficiency of services and cost-effectiveness. Monitoring occurs at:

- Plan level - oversight of the member's care through periodic reviews of health status and needs, evaluation of satisfaction with and use of services, and reports on the ongoing savings of disease-specific care
- Member level - review of clinical status and problems, communication with the physician and other members of the health care team, and use of satisfaction surveys

Implementation

Actions are taken to address the care needs identified in the assessment process and documented in the care management plan. The implementation of these actions includes working with the member's PPG to provide the needed services, referring members to community services or advocating provision of informal services by family and friends. The care manager supports the physician's plan of care through continually monitoring and finding new available resources.

Planning

Successful planning involves a multi-disciplinary approach developed by the provider and the care manager. This may include disciplines from both internal and key external parties, because each brings a unique perspective. Planning can occur formally in a care conference or informally through working individually with other providers. A care plan may be limited to arranging temporary home care after a hospital discharge or it may serve to integrate long-term health care, social services and informal care.

Care Management at PPG

Provider Type: Participating Physician Groups (PPG)

The following information is not applicable to Dual Special Need Plans.

Health Net members who are experiencing catastrophic and chronic injuries or illnesses are evaluated for care management services. Health Net delegated participating physician groups (PPGs) can use a variety of population data sources to identify members for care management, including, but not limited to:

- Data collected through utilization management (UM) processes, such as prior authorization and concurrent review
- Hospital admission data
- Hospital discharge data
- Claims and encounter data
- Pharmacy data

In addition to data identification, the care management program must have multiple avenues for members to be referred for care management services. This includes discharge planner referral, UM or concurrent review referral, member self-referral, and practitioner referral.

Care Management Vendors

For some conditions, ancillary providers contracting with Health Net to provide services can provide member care management related to those conditions. For specific ancillary provider information, contact the Health Net Care Management Department.

Initial Assessment and Ongoing Management

The care management process should be problem-focused and address risks. Goals should be actionable and address the member's needs. Documentation, typically kept in a care plan, needs to define issues, problems and appropriate interventions, and include follow-up evaluations. The care manager must document that the member was contacted and notified of their right to decline or disenroll from care management services.

The care management process must consider all of the following elements:

- Initial assessments of members' health status, including condition-specific issues
- Documentation of clinical history, including medications
- Initial assessment of activities of daily living (ADLs)
- Initial assessment of behavioral health status, including cognitive functioning
- Initial assessment of life-planning activities
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of caregiver resources and involvement
- Evaluation of available benefits within the organization and from community resources
- Development of care management plan with prioritized goals that consider the member and care-givers' preferences and desired level of involvement in the care plan
- Identification of barriers to meeting goals or complying with the plan
- Development of a schedule for follow-up and communication
- Development and communication of self-management plans
- Process to assess progress in care management plans
- Evaluation of visual and hearing needs and limitations
- Facilitation of member referrals to resources and follow-up process to determine whether the members act on referrals

In addition, Health Net may request feedback on members referred by the health plan to the PPG for care management screening.

Providing Tools to Care Managers

To assist care managers in monitoring cases, Health Net can provide PPGs with forms, tracking tools and information on how to access community resources for its members. Care management must be evidence-based and the systems and processes to support care management should use algorithmic logic, such as scripts or other prompts to guide care managers through the assessment and ongoing management of members.

Health Net care managers and provider service specialists can assist PPGs in obtaining tools and information necessary to direct Health Net members through the care continuum.

PPG Screening Criteria

Health Net members who meet the following criteria should be screened for care management services:

- Members with multiple admissions (two or more hospitalizations) within six months

- Members with multiple emergency room (ER) visits (three or more), or two hospital admissions, for the same condition within six months
- Members with multiple ER visits (five or more) for multiple conditions within six months
- Members who are eligible for public health programs
- Members who are accepted into clinical trials
- Pregnant members with high-risk conditions who require home health services
- Members identified through the health risk questionnaire process
- Members referred from Health Net's Care Management Department

For additional information, refer to Care Management Program Description.

Note: All Health Net Special Needs Plan (SNP) members are assigned a care manager; therefore, screening to meet specific criteria for program participation is not necessary.

Delineation of Care Management Responsibilities

To achieve the goals of the Health Net care management program, Health Net monitors care management processes to ensure there is no duplication of efforts between Health Net and participating physician groups (PPGs).

In some instances, the PPG or associated hospital has direct responsibility for specific tasks, such as authorization of professional services and on-site concurrent review. Other tasks are Health Net's responsibility, such as education of various key parties in the care management of members. Where shared responsibilities occur, communication between Health Net and the PPG becomes especially vital in ensuring that each operates as efficiently as possible.

Health Net Care Management Responsibilities

Health Net is responsible for the following care management activities when the PPG completes the member's care management functions:

- Provide oversight as required by regulatory agencies, such as the California Department of Managed Health Care (DMHC), the Centers for Medicare and Medicaid Services (CMS), and by accrediting entities, such as the National Committee for Quality Assurance (NCQA)
- Inform referral source of member's participation in the Health Net care management program
- Notify the provider that the member is assigned to the Health Net care management program
- Review the proposed plan of care with a Health Net regional medical director, as requested or indicated based on established processes
- Encourage providers and members to take responsibility for implementation of the care plan
- Monitor progress and service provided to the member
- Offer suggestions for revisions to the care plan to meet the changing health care needs of the member
- Serve as a source of information for the availability and costs of community resources within each geographic area
- Participate in meetings at hospitals, skilled nursing facilities (SNFs) and home health agencies as indicated when they pertain to member care management
- Evaluate the services provided and, with the provider and member, determine when the member should be discharged from the Health Net care management program (not applicable for SNP)

- Incorporate disease management into the care management program, as appropriate

PPG Care Management Responsibilities

The PPG is responsible for the following care management activities:

- Utilize the Health Net designated care management program for members who meet guidelines, such as state management and transplants
- Provide care management program activities meeting Health Net and regulatory standards
- Provide treatment and member-care documentation to Health Net when requested
- Participate in Health Net's care management program evaluation activities when requested by Health Net
- Provide feedback to Health Net on members referred by Health Net to the PPG for care management

Prospective Care Management

The Health Net prospective care management process begins with identification of at-risk members. Throughout this phase of the program, multiple modalities are used to evaluate the member's clinical and psychosocial status. Some of these modalities include health risk assessments, wellness programs, preventive measures, and evaluation of Healthcare Effectiveness Data and Information Set (HEDIS®) and risk management information. Identification and intervention is integrated with disease management programs.

Health Net's care managers collaborate with a team of Health Net medical directors, the primary care physician (PCP) and participating physician group (PPG) staff to coordinate identification and arrangement of care, the care plan, evaluation of the effectiveness of the care plan, and communication with the interdisciplinary team during all phases of treatment.

Medicare Advantage SNP CMS Requirements

Provider Type: Physicians | Participating Physician Groups (PPG)

The Medicare Improvements for Patients and Providers Act (MIPPA) mandates that all health plans have in place an evidence-based model of care program with the appropriate networks of providers and specialists. Requirements include:

- Case management program for all members.
- An initial health risk assessment within 90 days of member enrollment and annual reassessment of the individual's physical, psychosocial and functional needs.
- Development of an individualized care plan in consultation with the individual, if needed, that identifies goals and objectives, including measuring outcomes, as well as specific services and benefits to be provided.

- The member's risks are stratified to develop the care plan.
- An interdisciplinary care team in the management of care.
- Management of transitions - the organization monitors information on all members and identifies those who are at risk of experiencing a problem that could lead to a change in health status and a transition. Transition examples include transition from usual setting, such as home to hospital, skilled nursing facility, acute rehabilitation and inpatient hospice. Management of transitions includes communication of the care plan across care settings.
- Measurement of health outcomes and indices of quality to evaluate the effectiveness of the care management plan.

SNP Model of Care Goals

The Centers for Medicare & Medicaid Services' (CMS') model of care plan is a member-centric model designed to identify, acknowledge and incorporate the member's unique needs and goals into a cost-effective, individualized care plan. The program is designed to:

- Improve access to essential services, such as medical, behavioral health and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Ensure seamless transitions of care across health care settings, providers and services.
- Improve access to preventive health services.
- Ensure appropriate utilization of services.
- Improve beneficiary health outcomes.

The health plan owns the responsibility for all state specific and CMS required reporting based on regulations established by the Department of Health Care Services (DHCS) and CMS with regard to members enrolled in the SNP.

Care Coordination Road Map

Wellcare By Health Net providers can refer to the table below for an outline of responsibilities by the Health Plan, the provider group and for those that are shared between both.

The Health Plan	Shared Responsibilities	Provider Group
• Outreach of members identified for Care Management as post discharge and/or high priority based on provider notifications and/or internally derived algorithms • Conduct assessments with members	• Coordination or referral for services, as needed • Support managing chronic conditions to reduce hospitalizations	• Timely notification of admissions, transfers, or discharges to/from facilities to the Plan if the PPG is responsible for prior authorizations/ claims • Authorize all needed services where the provider group is/ remains delegated for

The Health Plan	Shared Responsibilities	Provider Group
• Create member-centric and member approved individualized care plans (ICP) • ICP creation/revisions (and related outreach) • Provider collaboration as a member of the interdisciplinary care team (ICT) • Coordinate/collaborate with the ICT team based on member risk/acuity/ needs • ·Facilitate ICT/IDCT meetings (and related outreach) as needed • Coordination of care • Assist with referrals to community-based resources for SDoH needs • Assist with access to benefits to address member identified needs • Address gaps in care		utilization management, if applicable • Communicate with Health Plan Case Management, as needed, to exchange information and ensure smooth transitions • Participation on ICT/ IDCT, if invited • Facility timely post-discharge appointments to PCP and or specialist, document efforts • Conduct care coordination on patient population based on need. • Refer high risk/ catastrophic members to Wellcare By Health Net for case management, if applicable • Coordinate activities with Wellcare By Health Net's case managers and ancillary providers as indicated

Palliative Care Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Eligible members (including Dual Special Needs Plans (D-SNPs)) at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or liver disease. Life expectancy is 12 months or less, health status continues to worsen and the emergency department (ED) or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

Referrals

Palliative care services provide extra support to current benefits.

Providers can refer an eligible member to palliative care. Send a Care Management Referral Form (PDF) and related medical records by email or fax to the Care Management Department. To process the request correctly, the following information must be included on the request:

- Diagnosis code – Z51.5
- Procedure code – S0311
- Units – 6 (equals 6 months)
- Select the contracted provider of choice from the Health Net Contracted Palliative Care Providers list (PDF).

Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in section A. below, and at least one of the four requirements outlined in section B.

Members under age 21 who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in section C. below, consistent with the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
    - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    - b.Participate in advance care planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive heart failure (CHF): Must meet (a) and (b)
    - a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
    - b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.
2. Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b)
    - a. The member has a forced expiratory volume (FEV) of one less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    - b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced cancer: Must meet (a) and (b)
    - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver disease: Must meet (a) and (b) combined or (c) alone
    - a.The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    - b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    - c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

Must meet 1. and 2. listed below. Members under age 21 may be eligible for palliative care and hospice services concurrently with curative care.

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
    - a. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
    - b. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
    - c. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
    - d. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

Targeting and Clinical Data Analysis

Provider Type: Physicians | Participating Physician Groups (PPG)

Initial identification of high-risk members is accomplished prospectively using health risk assessments, concurrently through Health Net's online databases of diagnostic information, and retrospectively based on medical and pharmacy claims and other data.

With early identification of potentially high-risk members, resources may be directed to those members at greater risk for poor health and higher costs. Certain factors, such as chronic health problems, lifestyle risks, family health, and quality-of-life considerations, influence medical care use. The Health Net care management program helps the member become a better-educated health care consumer and supports the provider by supplying vital information regarding the member and the member's care.

Clinical Criteria for Medical Management Decision Making

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to medical necessity clinical criteria for the evaluation and treatment of specific conditions and evolving medical technologies and procedures. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/ program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information.

Clinical polices do not constitute a description of plan benefits nor can they be construed as medical advice. These policies provide guidance as to whether or not certain services or supplies are cosmetic, medically necessary or appropriate, or experimental and investigational. The policies do not constitute authorization or guarantee coverage for a particular procedure, device, medication, service, or supply. In the event a conflict of information is present between a clinical policy, member benefits, legal and regulatory mandates and requirements, Medicare or Medicaid (as applicable) and any plan document under which a member is entitled to covered services, the plan document and regulatory requirements take precedence. Plan documents include, but are not limited to, subscriber contracts, summary plan documents and other coverage documents.

Clinical policies may have either a Health Net Health Plan or a “Centene” heading. Health Net utilizes InterQual® criteria for those medical technologies, procedures or pharmaceutical treatments for which a specific health clinical policy does not exist. InterQual is a nationally recognized evidence-based decision support tool. Clinical policies are reviewed annually and more frequently as new clinical information becomes available.

Continuity of Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The completion of covered services must be provided by a terminated provider to a member who at the time of the contract termination, was receiving services from that provider for one of the conditions described below.

Additionally, the completion of covered services must be provided by a non-participating provider to a newly covered member who, at the time their coverage became effective, was receiving services from that provider for one of the conditions below.

Conditions

- A serious chronic condition.
- A pregnancy.

- A terminal illness.
- The care of a newborn child between birth and age 36 months.
- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

For more detailed information refer to California Code, Health and Safety Code - HSC § 1373.96.

Refer to the Health Net Member Services Department for assistance.

Non-DSNP members COC services not covered for Medicare members are:

- Durable medical equipment (DME) providers or other ancillary services, such as transportation or carve-out services.
- Out-of-network providers who do not agree to abide by Health Net's utilization management policies.

For COC requirements for Dual Eligible Special Needs Plan (D-SNP) members, refer to the DHCS DSNP Policy Guide Section V. Medicare Continuity of Care Guidance for All D-SNPs.

Coverage Determination

Provider Type: Participating Physician Groups (PPG)

All delegated participating physician groups (PPGs) that make coverage determinations or prior authorization decisions for Health Net Medicare Advantage (MA) HMO members must follow the criteria of medical hierarchy, as follows, to determine medical necessity:

1. Medicare National Coverage Determinations (NCDs).
2. Medicare National Coverage Determinations (NCD) Manual (Publication 100-03).
3. Medicare Local Coverage Determinations (LCDs).
4. Other evidence-based clinical criteria, such as Health Net national medical policies and delegated PPG criteria.

Benefit coverage follows Medicare coverage guidelines unless otherwise specified in the member's Evidence of Coverage (EOC), such as carve-outs that may apply for vision, acupuncture or dental. In order to be eligible for coverage under Medicare, all services must meet applicable criteria for medical necessity.

National Coverage Determinations

To determine medical necessity, providers must first consult Medicare NCDs, which apply to Medicare members in all regions. NCDs are located on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.gov by:

1. Selecting documents to view.
2. Selecting the region in which the service is performed.

3. Searching by keyword, phrase or procedure codes.

Providers may use criteria from this page to state whether a specific request is a covered medical benefit or to support the medical necessity decision. If there is no documented NCD, providers must determine medical necessity by referring to the next step in the hierarchy, which is the NCD Manual.

National Coverage Determinations Manual

The NCD Manual describes whether specific medical items, services, treatment procedures, or technologies are covered under Medicare. The manual is located on the CMS website at www.cms.gov. If a service is not specifically listed in the NCD Manual, providers must determine medical necessity by referring to the next step in the hierarchy, the LCDs.

Local Coverage Determinations

LCDs are written coverage decisions of local Medicare Administrative Contractors (MACs) with jurisdiction for claims in the geographic area in which services are covered under Health Net's MA plans. Medicare LCDs apply to members in specific regions. Accompanying articles are used in conjunction with LCDs and are not meant to be used alone. LCDs are located on the CMS website at www.cms.gov by:

1. Selecting documents to view.
2. Selecting the region in which the service is performed.
3. Searching by keyword, phrase or procedure codes.

Providers may use criteria from this page to state whether a specific request is a covered medical benefit or to support the medical necessity decision. If a service is not specifically mentioned, providers must determine medical necessity via the next step in the hierarchy, evidence-based clinical criteria (such as Health Net national policies or delegated PPG clinical criteria).

An MAC outside of the plan's service area sometimes has exclusive jurisdiction over a Medicare-covered item or service. In some instances, one Medicare Part A and Part B MAC processes all of the claims for a particular Medicare-covered item or service for all Medicare beneficiaries around the country. This generally occurs when there is only one supplier of a particular item, medical device or diagnostic test (for example, certain pathology and lab tests furnished by independent laboratories). In this situation, delegated PPGs must follow the coverage requirements or LCDs of the MAC that enrolled the supplier and processes all of the Medicare claims for that item, device or test.

Other evidence-based clinical criteria

Other evidence-based clinical criteria include Health Net national medical policies and delegated PPG criteria.

Health Net National Medical Policies

If providers do not find results from the NCDs, NCD Manual or LCDs search, they should refer to the Health Net national medical policies. PPGs may access medical policies on the Health Net provider website under Resources for You. Updated policies feature a grid and instructions that outline what resources can help to determine medical necessity. Resources are listed in the order that they should be utilized. If a resource is

blank, it may be due to the fact that at the time of writing or revising the policy no Medicare coverage criteria existed, in which case providers must conduct a more specific search of the NCDs, NCD Manual or LCDs site.

Delegated PPG Criteria

If no results appear or the results are vague in the NCDs, NCD Manual, LCDs, and Health Net national medical policies, providers must search the individual PPG criteria set.

Documenting Medical Necessity

PPGs must thoroughly document the criteria they used to review for medical necessity (NCDs, NCD Manual, LCDs, Health Net national medical policies, or delegated PPG criteria). Documentation must be able to lead an auditor through the steps taken to prove medical necessity. If criteria are vague or unavailable, providers must follow internal policy and forward the inquiry to the medical director, including documentation of the sources reviewed and lack of criteria found.

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.

Health Risk Assessment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net performs aggressive outreach to newly enrolled members to complete the health risk assessment (HRA) within 90 days after the effective date of enrollment and annually, depending on specific program

requirements. This enables the Health Net care management team to begin managing potentially high-risk members. The care manager collaborates with the member, using the HRA to develop the care plan. Additionally, the HRA assists the primary care physician (PCP) in identifying and intervening to meet care needs.

The HRA completion assists in predicting future consumption of medical care and is imperative to the success of the care management program for both the participating physician group (PPG) and Health Net. With early identification of member needs, resources may be directed to those members at greater risk for poor health. Certain factors, such as chronic health problems, lifestyle risks, family health, and quality-of-life considerations, influence medical care. Parallel analysis of prospective, concurrent and retrospective data sets allows the care management team to provide members with their best efforts to reach and maintain the best possible health status given the member's condition. The Health Net care management program helps the member become a better-educated health care consumer and supports the provider by supplying vital information regarding the member and the member's care. Educated members require fewer visits and interventions from providers and staff. In addition, informed members have better treatment outcomes and faster recovery times.

Medical Data Management Reporting

Participating Physician Groups (PPG) | Hospitals

Information is gathered through the Health Net Utilization Management System (Unity) and claims system (ABS) to develop UM reports for each participating physician group (PPG) and Health Net internal staff. Initial reports include standard UM information (for example, average length of stay (ALOS) and bed-days per thousand members per year). This information assists in managing the provision of medical services.

Health Net monitors the effectiveness of plan-wide UM programs through the following reports:

1. The inpatient census and detailed claims reports provide utilization information on the number of inpatient admissions, skilled nursing facility (SNF) admissions, emergency room visits and outpatient surgeries on a monthly, year to date, rolling 12-month and calendar year basis. This report gives UM staff and PPGs the ability to compare and manage hospital days in relation to the network benchmarks set at the 25th, 50th and 75th percentiles
2. Hospital services are described and assessed through several individual reports, which provide performance measures for patients by assigned PPGs and for patients in the aggregate Health Net membership. Key metrics for each admission are reported for the month in which the patient was admitted. Each hospitalization is classified by service category Analytic Terminology Of Service code (ATOS) and DRG. The key metrics for each ATOS code or DRG include the total admissions, average length of stay, total bed days and total billed charges
3. The 30-Day Re-Admits Report identifies inpatient re-admissions to any facility for any diagnosis within 30 days of a patient's discharge from an acute facility. This report is PPG-specific. It is run monthly and tracks trends over multi-month and multi-year intervals. The report criteria includes admissions to any facility for any diagnosis within 30 days of discharge from an acute facility. A subset of this report measures acute hospital (re)admissions from the SNF

- The 30-Day Re-Admits by Primary Care Physician (PCP) Report is similar to the 30-Day Re-Admits Report, but all utilization information is related to the member's PCP

Medical Data Management System

Provider Type: Physicians | Participating Physician Groups (PPG)

The Health Net utilization management (UM) program is supported by Unity, Health Net's medical management system. Unity provides an integrated database for Health Net UM activities. The system supports business management, drives regulatory compliance, and optimizes automation. It also provides medical management with the data to identify trends or patterns.

Health Net reviews encounter data to determine whether membership is accurately represented, to confirm that the data is submitted within contractual time frames and is within normative rates; for example, if an encounter rate is greater than 10 percent of a normative standard or the services provided per member per year is below six encounters. Health Net discusses actions for improved utilization management with the participating physician group (PPG).

Medicare Certified Facilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

In accordance with the Medicare Managed Care Manual (100-16), Chapter 6, Section 70, Institutional Provider and Supplier Certification, the Centers for Medicare and Medicaid Services (CMS) requires health plans to comply with all CMS requirements related to an approved benefit, and the use of approved Medicare-certified facilities for performing certain surgical procedures. This includes positron emission tomography (PET) scans in Medicare-specified studies.

Applicable Procedures

The following procedures must be performed at Medicare-certified facilities:

- Carotid artery stenting
- Ventricular assist device (VAD) destination therapy
- Certain oncologic PET scans in Medicare-specified studies
- Lung-volume reduction surgery

When performing the above procedures, in addition to confirming the facility is Health Net participating, Health Net participating providers must refer to the CMS website at www.cms.gov to ensure the facility where the procedure is being performed is Medicare-certified. Once on the site, review the list in the left-hand menu bar for the applicable procedure.

Non-Delegated Medical Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net does not delegate performance of the utilization management (UM) function to fee-for-service (FFS) participating providers. Health Net performs UM, quality improvement (QI) and care management functions.

Health Net uses InterQual criteria, Medicare guidelines, Hayes Medical Technology Directory®, Health Net medical policies, and MHN level-of-care criteria as the basis for making utilization decisions. Case-specific determinations of medical necessity are based on the needs of the individual member and the characteristics of the local network. Appropriate providers are involved in the adoption, development, updating (as needed), and annual review of medical policies and criteria. Delegated participating physician groups (PPGs) and MHN are required to use approved scientifically based criteria. Health Net national medical policy statements are currently available on the Health Net provider portal. Medical policy statements and other clinical criteria, such as InterQual and Hayes Technology Assessments, are available to all Health Net PPGs upon request by calling the Health Net Provider Services Center.

Non-Delegated Concurrent Review

Health Net's concurrent review staff perform clinical reviews when UM functions are not delegated. The objective of concurrent review is to review clinical information for medical necessity during a member's hospital confinement, coordinate discharge plans, and screen for quality of care concerns.

The hospital is required to notify Health Net's Hospital Notification Unit within 24 hours of admission or one business day when an admission occurs on a weekend, whenever a Health Net member is admitted. Failure to notify according to the requirements in the Provider Participation Agreement (PPA) may result in a denial of payment. The first review occurs within 24 hours or one business day of admission and is performed either on-site or over the telephone by a Health Net concurrent review nurse.

Use of standardized review criteria is required to ensure consistency of decision-making. Health Net's concurrent review nurses use InterQual guidelines to determine medical necessity of the inpatient stay. Review of the medical records is performed as required on an ongoing basis.

If, based on available information, an acute level of care is determined to be no longer necessary, Health Net's concurrent review nurse reviews the clinical information with a Health Net regional medical director. The Health Net concurrent review nurse also notifies the Hospital Utilization Review Department that the continued stay is in question. Discussion with the Health Net regional medical director focuses on alternate levels of care and discharge plans.

If the Health Net regional medical director determines that based on available medical information the member is ready for discharge, the attending physician is contacted to discuss alternatives. If the attending physician agrees with the Health Net regional medical director, the member is discharged to home or transferred to an appropriate, lower level of care. Concurrent review staff work with the PPG staff to monitor the member's care, and coordinate transfers and any needed post-discharge services.

If the attending physician and the Health Net regional medical director disagree, Health Net may issue a denial letter to the hospital, with copies to the attending physician, the PPG or the member. A denial letter contains the basis for the denial and information on the appeals and grievance process, as required by state and federal

law. For Medicare Advantage (MA) members, Health Net follows the Centers for Medicare and Medicaid Services (CMS) guidelines when issuing a denial letter.

Non-Delegated Prospective Review

Under the terms of a member's coverage with Health Net, Health Net must provide pre-service authorization for elective inpatient services and selected outpatient procedures for PPO providers and participating fee-for-service (FFS) HMO providers. This also applies to contracting providers rendering services under Tier 2 Point of Service (POS) benefits. Following review by a Health Net medical director, authorization is approved or denied and communicated in writing to the PPG or requesting physician and the member.

When requesting a pre-service authorization for elective services or selected outpatient procedures, documentation by the referring participating physician must include:

- Prior written authorization request for specified outpatient services, specifying:
  - Services requested and number of visits
  - Information about previously attempted but unsuccessful treatments
  - Sufficient clinical information to establish medical necessity

  Providers may use the appropriate forms below or refer to the Prior Authorization topic for additional information.

  Inpatient California Health Net Commercial Prior Authorization (PDF)

  Outpatient California Health Net Commercial Prior Authorization (PDF)

  Inpatient California Health Net Medicare Authorization Form (PDF)

  Outpatient California Health Net Medicare Authorization Form (PDF)

- Prior written authorization request for hospitalization which is submitted by the PCP or specialist must include:
  - Necessity of admission
  - Pre-admission work-up
  - Number of medically necessary inpatient days
- If admission is denied, the requesting physician and member is sent the following information:
  - Written rationale for denial with the specific reason delineated
  - Information as to how to appeal Health Net's determination
  - Suggestions for alternative treatment

  Health Net does not pay claims without a Health Net authorization number. Authorization and claims dates must correspond, and the service type must match before payment can be rendered. If the dates of service change after the authorization number has been issued, the provider is required to notify Health Net. When a claim is received without a Health Net authorization number or the dates and services do not match the recorded authorization, further investigation is conducted by the Medical Review Unit (MRU). MRU examines hospital records and authorization notes in Unity to reconcile the discrepancies.

Non-Delegated Retrospective Review

Retrospective review is the review of medical services after care has been rendered. Retrospective review involves an evaluation of services that fall outside Health Net's established guidelines for coverage or require a medical necessity or benefit determination to authorize a request for payment of a claim.

Notification of Hospital Admissions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Timely notification of Health Net member inpatient admissions assists with timely payment of claims, reduces retroactive admission reviews and enables Health Net to concurrently monitor member progress. Health Net requires the following facilities to notify BOTH Health Net Hospital Notification Unit AND the PPG or provider of a member's inpatient admission within 24 hours or one business day when an admission occurs on a weekend for the following services:

- All inpatient hospitalizations.
- Skilled nursing facility (SNF) admissions.
- Inpatient rehabilitation admissions.
- Inpatient hospice services.
- Emergency room admissions.

Hospitals are required to report any Health Net member's inpatient admissions (including Individual Family Plan (IFP) within 24 hours or one business day when an admission occurs on a weekend. To report an admission, contact the Health Net Hospital Notification Unit. Failure to notify according to requirements in the Provider Participation Agreement (PPA) may result in a denial of payment.

Inpatient admissions may be reported by fax, 24 hours a day, seven days a week. A Health Net representative verifies eligibility, obtains information regarding the admission, and, if applicable, provides a tracking number for the claim.

When reporting inpatient admissions, providers must have the following information:

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).
- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number.
- For obstetrical (OB) delivery admissions, include newborn sex, weight, apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

On receipt of admission notification, authorized services are entered into the Health Net's notification system and a tracking number is created and provided to the reporting party. The tracking number is also transferred electronically to the Health Net claims processing system.

The tracking number is not an authorization that services are covered under a member's benefit plan.

Telephone coverage is provided 24 hours a day, seven days a week for non-participating facilities reporting post-stabilization. Note: plans for which Department of Managed Health Care (DMHC) provides oversight (HMO, POS, Elect, Elect Open Access) have telephone coverage 24 hours a day, seven days a week for non-participating facility requests for prior authorization of services for patients deemed stabilized.

Providers can access the Transitions of Care Management (TRC) Worksheet to:

- Help support transitions of care to ensure appropriate documentation and timely report of the notification of a Medicare patient's inpatient admission, receipt of discharge information, and patient engagement after inpatient discharge.
- Reconcile discharge medications with the most recent medication lists to optimize HEDIS® and Star Rating scores and improve care coordination.

Wellcare By Health Net Medicare Dual Special Needs (D-SNP)

Per the State Medicaid Agency Contract (SMAC) with Department of Health Care Services (DHCS) contracted hospitals and SNFs must use one of the following methods, in a timely manner, to inform the member's D-SNP and the Medi-Cal plan of any hospital or SNF admission, transfer or discharge. Hospitals and SNFs must use either:

- A secure email or data exchange through a Health Information Organization or,
- An electronic process approved by DHCS.

This information must be shared to the extent allowed, under applicable federal and state law and regulations, and not be inconsistent with the member's expressed privacy preferences.

Contracted hospital	Must notify the D-SNP member's MCP either immediately prior to, or at the time of, the member's discharge or transfer from the hospital's inpatient services, if applicable.
Contracted SNFs	Must notify the D-SNP member's MCP within 48 hours after any SNF admission. For discharges or transfers, SNFs must notify the D-SNP member's MCP in advance if possible, or at the time of the member's discharge or transfer from the SNF

Facilities can identify the member's Medi-Cal plan by using the State online eligibility system (AEVS).

Notification of Hospital Discharge Appeal Rights

Provider Type: Participating Physician Groups (PPG) | Hospitals

Hospitals must deliver a standardized written notice to members of their rights as a hospital inpatient, including discharge appeal rights. Hospital providers are to provide the notice at or near admission, but no later than two calendar days following the member's admission to the hospital. Hospitals must issue an Important Message from Medicare about Your Rights (IM) Form to notify all patients of their rights. If a patient disagrees with the proposed discharge, they can ask the Quality Improvement Organization (QIO) to make an expedited determination of the need for a longer hospital stay. Soon after the patient, or the patient's authorized representative, makes this request, the hospital provider, delegated participating physician group (PPG) or Health Net must issue a Detailed Notice of Discharge (DND) to the patient as well as provide all requested medical records at the QIO's request as soon as possible, but no later than 12:00 p.m. the day following notification of the appeal by the QIO. If the hospital does not issue the DND, Health Net and its delegated participating providers must work together to issue the DND letter to the patient being discharged from the acute facility.

The QIO, which operates 365 days a year, notifies Health Net upon making its determination. A representative from Health Net contacts the hospital and PPG case manager to inform them of the QIO's appeal issue determination, including on weekends and holidays.

If the QIO reverses the discharge determination decision to terminate covered services, the hospital provides the member or authorized representative with a new IM notice when the treating physician determines that the member no longer requires acute inpatient hospital care.

MA providers can download the Centers for Medicare and Medicaid Services (CMS)-approved Health Net MA templates from the ICE website.

Out-of-Area Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Health Net provides authorization, concurrent and retrospective utilization review, and care management assistance to members who receive emergency inpatient care outside their service area. Members are encouraged, when possible, to contact their primary care physician (PCP) or participating physician group (PPG) to determine the best plan for obtaining medical care and follow-up when out of the service area. When Health Net is contacted, the Utilization Management (UM) Department notifies the PPG of the member's location and clinical condition. The Health Net UM staff assists the member's PCP, PPG and receiving facility in determining whether the member, in the opinion of the treating provider, can safely be transferred to a Health Net participating facility provider. If it is determined that the member can be safely transferred, Health Net nurses assist as needed with the transfer.

Separation of Medical Decisions and Financial Concerns

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Under California Health & Safety Code Section 1367(g), medical decisions regarding the nature and level of care to be provided to a member, including the decision of who renders the service (for example, primary care physician (PCP) instead of specialist or in-network provider instead of out-of-network provider), must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization management (UM) decisions are, therefore, made by medical staff and based solely on medical necessity. Providers may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. Health Net requires that each participating physician group (PPG) and hospital's UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions, and that each member of the PPG's UM staff sign an acknowledgment of this. Failure to comply may result in withdrawal of delegated UM and ultimately, termination of the Provider Participation Agreement (PPA) with Health Net.

Medicare Benefits and Beneficiary Protections

Health Net provides members, at a minimum, with all basic Medicare-covered services by furnishing benefits directly or through our PPG arrangements, or by paying for benefits. Health Net also provides mandatory and optional supplemental benefits. In addition, as a Medicare Advantage Organization (MAO), Health Net and its delegated PPGs must comply with Centers for Medicare and Medicaid Services (CMS) national coverage decisions, general coverage guidelines included in original Medicare manuals and instructions (unless superseded by regulations), and written coverage decisions of local Medicare contractors. Given that Health Net covers geographic areas encompassing more than one local coverage policy area, Health Net and its PPGs must apply the Medicare coverage policy specific to the member's service area

Termination of Provider Services

Participating Physician Groups (PPG) | Ancillary

A termination of service is the discharge of a member from covered provider services, or discontinuation of covered provider services, when the member has been authorized by Health Net or the participating physician group (PPG) to receive an ongoing course of treatment from that provider, including home health agencies (HHAs), skilled nursing facilities (SNFs) and comprehensive outpatient rehabilitation facilities (CORFs). Termination includes cessation of coverage at the end of a course of treatment pre-authorized in a discrete increment, regardless of whether the member agrees that such services should end.

Advance Written Notification of Termination

Prior to any termination of service, the provider of service must deliver a valid written notice to the member of the decision to terminate the services. The provider must use the standardized notice, and follow specific procedures regarding timing and content of the notice. The standardized termination notice must include:

- The date coverage of services ends
- The date the member's financial liability for continued services begins
- A description of the member's right to a fast-track appeal, including information on how to contact the independent review entity (IRE), a member's right to submit evidence showing that services should continue, and the availability of Health Net's Medicare appeal procedures if the member fails to meet the deadline for a fast-track IRE appeal
- The member's right to receive detailed information about the termination notice and all documents sent by the provider to the IRE

The Notice of Medicare Non-Coverage (NOMNC) is issued at least two days in advance of the ending of approved coverage for SNF, HHA or CORF services.

The Detailed Explanation of Non-Coverage (DENC) is issued when the member does not agree that covered services should end. The member may appeal by requesting an expedited appeal review of the case by the Quality Improvement Organization (QIO). Health Net or its delegated PPG must furnish the DENC explaining why the services are no longer necessary or covered on the day the QIO notifies the plan of the member's expedited appeal.

Providers may download the Centers for Medicare and Medicaid Services (CMS)-approved Health Net Medicare Advantage templates from the Industry Collaboration Effort (ICE) website at www.iceforhealth.org.

Utilization Management Goal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The goal of the Health Net Utilization Management (UM) and care management (CM) programs is to provide members with access to the health services delivery system in order to receive timely and necessary medical care in the correct setting. Health Net's UM and CM programs comply with all applicable federal and state laws, regulations and accreditation requirements. The UM system is also intended to analyze and measure effectiveness while striving for improvement of services. Health Net's UM system separates medical decisions from fiscal and administrative management to assure that medical decisions are not unduly influenced by fiscal and administrative management.

Health Net gathers encounter data from participating physician groups (PPGs) (if applicable) and data from the Health Net Medical Management System to monitor potential indicators over- and under-utilization. Based on the classification of delegation, the following types of data are collected:

- System-wide data:
  - Member services complaints
  - Member satisfaction surveys
  - PPG transfer rates
- PPG data:
  - Encounter data
  - Unity system reports (such as Monthly Census and Detail reports)
  - PPG report card (profile reports of utilization statistics)

- UM denial and appeal logs

Utilization Management Program Components

Physicians | Participating Physician Groups (PPG)

Utilization management (UM) is provided through a comprehensive, multi-level and flexible managed care delivery system. Health Net delegates the UM function to participating physician groups (PPGs) following an evaluation of the operational capabilities and performance of each group in the areas of administration, UM, member services, quality improvement (QI), and encounter data submission. Based on Health Net's evaluation, the PPG is assigned delegation or non-delegation status. Health Net does not delegate UM functions to individual participating providers.

These two performance categories define the interface between Health Net and the PPG and allow each PPG to be involved in the medical management process in a manner consistent with the PPG's current level of management sophistication and administrative resources. The categories are administered by Health Net and include different degrees of oversight and operational support.

When Health Net delegates UM operational functions to PPGs, PPGs 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 before UM is delegated and at least annually thereafter. Health Net staff perform UM functions when operational functions are not delegated.

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

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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

- Access2Care
- Access to Interpreter 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

- Cancer Information Services
- Centralized Transplant Unit
- Centers for Medicare & Medicaid Services
- Connect Hearing, Inc
- Coram
- Custom Rehab Network

D

- Delta Dental
- Dental Benefit Providers
- Department of Managed Health Care

E

- Electronic Claims Clearinghouse Information
- EviCore Healthcare

F

- Financial Oversight Department
- FitOn Health

G

H

- Health Net Care Management Department
- Health Net Continuity and Coordination of Care Department
- Health Net Credentialing Department
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Encounter Department
- Health Net Fraud Hotline
- Health Net's Health and Wellness Referral Fax
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Mail Order Prescription Drug Program
- Health Net Marketing Department
- Health Net Medicare Advantage Claims Department
- Health Net Medicare Advantage Provider Disputes
- Health Net Medicare Appeals and Grievances Department
- Health Net Medicare Member Services Department
- Health Net Medicare Programs Provider Services Department
- Health Net Provider Communications Department
- Health Net Overpayment Recovery Department
- Health Net Prior Authorization Department
- Health Net Program Accreditation Department
- Health Net Quality Improvement Department
- Health Net's Regional Medical Directors
- Health Net Transfer/Termination Request Unity
- Health Net Transportation Vendors
- Health Net Utilization Management Department
- Hearing Care Solutions
- HNI Corporate Address
- Hoveround, Inc

I

J

K

- Kick It California

L

- LabCorp
- Linkia, LLC
- Livante (California Quality Improvement Organization)

M

- Matria Health Care, Inc
- Medicare Appeals Council
- MiniMed Distribution Corp, Inc
- Modivcare

N

- National Seating and Mobility
- Nurse Advice Line

O

P

- Peer-to-Peer Review Request Line
- Pharmacy Services
- Premier Eye Care
- Provider Network Management Department

Q

- Quest Diagnostics

R

- Reinsurance Claims Unit
- Roche

S

- Smiths Medical, Inc
- Solutran

T

- Teladoc Health™

U

V

- VRI

W

- Wellcare By Health Net (Health Net) Member Services Department

X

Y

Z

Glossary

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

- AIDS
- Appeal
- Certificate of Insurance (COI)
- Clean Claim
- Clinical Trials
- Complaint
- Emergency
- Evidence of Coverage (EOC)
- Facility Site Review
- Grievance
- Hospice Services
- Inquiry
- Investigational Services
- Medical Necessity
- Medical Waste Management Materials
- Medical Information
- Member Handbook
- Not Medically Necessary
- Offshore
- Opt Out Provider
- Participating Provider
- Primary Care Physician (PCP)
- Psychiatric Emergency Medical Condition
- Residential Treatment
- Telehealth
- Schedule of Benefits or Summary of Benefits (SOB)
- Serious Illness
- Subcontractor
- Unclean Claim

PDF Forms and References in Alphabetical Order

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#

- 837 5010 Professional and Institutional Standards
- 837 Institutional Companion Guide
- 837 Professional Companion Guide

A

- Adult AIDS/HIV Confidential Case Report (PDF)
- After-Hours Sample Script - Chinese (PDF)
- After-Hours Sample Script - English (PDF)
- After-Hours Sample Script - Spanish (PDF)
- Annual Care for Older Adults (COA)/Advance Care Planning (ACP) Form (PDF)
- Appointment of Representative - Spanish (PDF)
- Autoclave Log (PDF)

B

C

- Capitation Activity Analysis Report Field Descriptions (PDF)
- Capitation Eligibility Summary Report by Group/Provider (BRM 11)(PDF)
- Capitation Remittance Remittance Detail Report (BRM 20) (PDF)
- Care Management Referral Form - Commercial and Medicare (PDF)
- Certification for Contracts Grants, loans, and Cooperative Agreements (PDF)
- Chronic Condition Verification Form (PDF)
- Clinical Payment Policy CP.MP.152 - Measurement of Serum 1 25-dihydroxyvitamin D (PDF)
- Clinical Payment Policy CP.MP.153 - Helicobacter Pylori Serology Testing (PDF)
- Clinical Payment Policy CP.MP.154 - Thyroid Hormones and Insulin Testing in Pediatrics (PDF)
- Clinical Payment Policy, CCP.MP.155 - EEG in the Evaluation of Headache (PDF)

- Clinical Payment Policy CP.MP.156 - Cardiac Biomarker Testing for Acute Myocardial Infarction (PDF)
- Clinical Payment Policy CP.MP.157 - 25-hydroxyvitamin D Testing in Children and Adolescents (PDF)
- Clinical Payment Policy CP.MP.38 - Ultrasound in Pregnancy (PDF)
- Cold Sterilization Log (PDF)
- Confidential Morbidity Report (PDF)
- Criteria for Hospice Appropriateness (PDF)

D

- Decision Power Referral Fax Form - Commercial and Medicare (PDF)
- Diagnostic Procedures Requiring Prior Authorization for Health Net of California (PDF)
- Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Coding Policies (PDF)

E

- Eligibility Report Field Descriptions (PDF)
- Eligibility Summary by Group File (PDF)
- Eligibility Summary by Group and Provider Report Field Descriptions (PDF)
- Endoscopy Matrix (PDF)
- ESRD Medical Evidence Report (PDF)
- Expedited Organization Determination (EOD) (PDF)

F

G

- Government Programs Electronic Media Format Activity File (PDF)
- Government Programs Electronic Media Format Eligibility File (PDF)
- Government Programs Electronic Media Format Member Status Table (PDF)
- Government Programs Electronic Media Format Remittance Detail File (PDF)

H

- Hepatitis B Vaccination Declination (PDF)
- Hospice Consideration Request Letter (PDF)
- Hospital Reinsurance Example (PDF)

I

- Identification card (Medicare Advantage Seniority Plus) (PDF)
- Identification card (Medicare Advantage Prescription Drug Plan) (PDF)
- Identification card (Wellcare By Health Net) (PDF)
- Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations (PDF)
- Injectable Medication HCPCS/DOFR Crosswalk (PDF)
- Inpatient California Health Net Medicare Prior Authorization Form (PDF)
- Interpreter Service Quick Reference Card (PDF)

J

Jade-C SNP

K

L

- Language Identification Poster (PDF)
- Linkage/Enrollment Tracking Log for Initial Health Appointment (PDF)

M

- Medical Record - Adult Health Maintenance Checklist With Standards (PDF)
- Medical Record - Advance Directive Labels (PDF)
- Medical Record - Audiometric Screening (PDF)
- Medical Record - History Spanish (PDF)
- Medical Record - Medication and Chronic Problem Summary (PDF)
- Medical Record - Signature Page (PDF)
- Medical-Behavioral Comanagement Coordination of Care Form (PDF)
- Medicare and Medicare-Medicaid Plans Prescription Claim Form (PDF)
- Medicare Capitation Activity Analysis Report (BRM 30) (PDF)
- Medicare Informational Letter to Patient and/or Provider/Physician (PDF)
- Medicare Member Claim Form (PDF)
- Medicare Prior Authorization -Formulary Exception Request Fax Form (PDF)
- Medicare Provider Termination Notification Template-MA H0562 (PDF)
- Medicare Provider Termination Notification Template-DSNP H3561 (PDF)

N

Non-discrimination Notice and Taglines (PDF)

O

- Offshore Subcontracting Attestation: Participating Provider (PDF)
- Outpatient California Health Net Medicare Prior Authorization Form (PDF)

P

- Palliative Care Providers (contracted)
- PDR Overturn Letter (PDF)
- PDR Uphold Letter (PDF)
- Physical or Speech Therapy (PDF)
- Potential Quality Issue Referral Form (PDF)
- Pre-qualification Assessment Tool (PDF)
- Primary Care Services Eligible for Primary Care Incentive Payments in Calendar Year 2011 (PDF)
- Prostate Cancer Treatment Information Sign (PDF)
- Provider Dispute Resolution Request - Medicare (PDF)
- Provider Medicare Marketing Material Review Submission Check List (PDF)

Q

- Quick Reference Guide (PDF)
- Quick Reference Sheet (PDF)

R

- Reconstructive Surgery Decision Tree (PDF)
- Remittance Detail Report Field Descriptions (PDF)
- Reopen Request Form (PDF)
- Reportable Diseases (PDF)

S

- SB 260 Reconciliation Report (BRM_28) (PDF)
- SB 260 Reconciliation Report Format Exhibits I-II (PDF)

- Shared-Risk Settlement Example (PDF)

T

- Transfer or Termination Incident Report (PDF)
- Transitions of Care Management Worksheet
- Transplant Request - BMT/PBSCT (PDF)
- Transplant Request - Heart (PDF)
- Transplant Request - Heart/Lung (PDF)
- Transplant Request - Kidney (PDF)
- Transplant Request - Kidney/Pancreas (PDF)
- Transplant Request - Liver (PDF)
- Transplant Request - Lung (PDF)
- Transplant Performance Centers (PDF)

U

- Urgent Request for Continuing Home Health Services (PDF)
- Urgent Request for Continuing Occupational, Physical or Speech Therapy (PDF)
- Utilization Management Timeliness Standards - Medicare (PDF)

V

W

Weekly Inpatient Denial Log Sheet (PDF)

X

Y

Z

Health Net, LLC.

HIPAA Transaction 837 Professional
Standard Companion Guide

Refers to the Implementation Guides Based on X12 version 005010X222A1

Companion Guide Version Number: 2.1

February 22, 2019

Disclosure Statement

This Companion Guide describes the EDI requirements for the submission of CA and Arizona Encounters to Health Net. Throughout the remainder of this document Health Net, LLC. will be referred to HNT to describe the all regions of Health Net.

Preface

This Companion Document to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Health Net, LLC. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usage of data expressed in the ASC X12N 837 Implementation Guides.

EDITOR'S NOTE:
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1 Introduction

1.1 Scope

This Companion document supports the implementation of a batch processing application.

HNT will accept inbound submissions that are formatted correctly in X12 requirements. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide.

HNT EDI applications will edit for these conditions and reject files that are out of compliance.

This companion document will specify everything that is necessary to conduct EDI for this standard transaction. This includes;

- Specifications on the communications link
- Specifications on the submission methods
- Specifications on the transactions

1.2 Overview

This companion guide complements the ASC X12N 837 Professional implementation guide currently adopted by HIPAA.

This companion guide will be the vehicle that HNT uses with its trading partners to further qualify the HIPAA adopted implementation guide. This companion guide is compliant with the corresponding HIPAA implementation guide in terms of data element and code sets standards and requirements.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are:

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Trading partner profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

1. Health Care Claim: Professional
   - 837 (005010X222A1)

1.4 Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between trading partners. The computer system generating the transactions must supply complete and accurate information while

the system receiving the transactions must be capable of interpreting and utilizing the information in ASC X12N format, without human intervention.

The transactions must be sent in a specific format that will allow HNT's computer application to translate the data. HNT supports the standard transactions adopted from HIPAA. Maintains a dedicated staff for the purpose of enabling and processing X12 EDI transmissions with its trading partners.

It is the goal of HNT to establish trading partner relationships and to conduct EDI as opposed to paper information flows whenever and wherever possible.

1.5 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.
HIPAA covered healthcare providers that choose to submit transactions electronically, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, the National Provider Identifier (NPI) is meant to be a lasting identifier, and would not change based on changes in a health care provider's name, address, ownership, membership in health plans or Healthcare Provider Taxonomy classification.
HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans (including Health Net), must use only the NPI in the primary identifier position to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

This companion guide has been updated to reflect how the NPI will be integrated in the 837 X12 transaction.

2 Getting Started

2.1 Working with Health Net, LLC

Contact HNT EDI Dept. for all EDI related customer service requests. (Contact information is identified in section 5 below.)

There are three units within HNT that work internally to complete EDI service requests from our trading partners.

The first unit is HNT EDI Operations Dept. This group will serve as the trading partner's central point of contact. This group will also facilitate the implementation of trading partners through all steps of external testing.

The second unit is HNT EDI IT infrastructure group. This is a technical team that implements the communication link and ensures that trading partner to payer connectivity is established properly.

The third unit is HNT EDI IT Translator team. This group is responsible for our inbound and outbound X12 Translator applications.

2.2 Trading Partner Registration

To register as a trading partner with HNT the following sequence of events will take place.

1. Initial conversations are held between the trading partner and HNT
2. Verbal agreements are reached to agree on the transactions that will be conducted.
3. A trading partner agreement and associated companion guides are provided and reviewed.
4. Submitter Id and Receiver Id are established for the purpose of identification.
5. Required trading partner profiling is built into our HNT EDI translator.
6. Test files are exchanged and test runs conducted.
7. Once a brief testing phase is completed and a trading partner agreement is in place; the trading partner is registered.

2.3 Certification and Testing Overview

HNT requires its trading partners to show evidence of third party certification. This is consistent with industry standard conventions that have been adopted for HIPAA Transactions and Code Sets implementation.

HNT will also show evidence of third party certification for standard transactions.

This requirement exists so that the process to test and implement a trading partner for the purpose of conducting EDI with standard transactions is a smooth and efficient process.

The complexity of X12 files when not tested and certified by a third party will cause delays in the ability to enable the X12 submissions in a production environment.

HNT wants to spend the majority of the testing period time, working with prospective trading partners on the agreed components of this companion document rather than X12 or HIPAA implementation guide syntax.

HNT will be certified incorporating the following WEDI/SNIP levels of testing where applicable:
Level 1, Integrity Testing (X12 Syntax)
Level 2, Requirement Testing (HIPAA Implementation Guide Syntax)
Level 3, Balancing Testing (i.e. 835 claim line balancing to the claim document)
Level 4, Situation Testing (Use of Situational Segments that business relevant
Level 5, Code Sets Testing
Level 6, Product Types/Types of Service Testing (i.e. provider specialties)

3 Testing with the Payer

HNT would like to establish with the trading partner a set of scenarios that are intended for testing. This can be a high level description of the contents of the transaction. It should be a representation or cross section of the majority of conditions that will be encountered with production data from these transactions.

HNT requires testing be completed with all trading partners. The testing phase will consist of several smaller phases of testing, as appropriate.

3.1 HIPAA Compliance Testing

HNT uses an industry standard data translator to validate transactions meet the 6 levels of HIPAA compliance, and to translate them into an acceptable format for internal processing. The 997/999 Acknowledgement will be tested during this phase. Any issues identified during this phase of testing will have to be addressed in order for subsequent phases to continue. HNT will use the 277CA for claims acknowledgements.

3.2 Trading Partner Agreement Testing

Trading partner specific setup, as defined in either the trading partner agreement or companion guide will be verified. Generally, this will be done in conjunction with Compliance testing.

3.3 Functional and Regression Testing

Once the transactions have successfully tested through GXS and trading partner specifications, they will be processed through our internal system to ensure they are handled appropriately. Response transactions will be generated during this phase, where applicable.

3.4 Parallel Testing

Depending on the stage of the HNT implementation, a period of parallel testing may be required. This would involve sending the current proprietary transaction format, as well as, sending the same transactions in the x12 format, to our test system. This phase will allow for the comparative analysis necessary to ensure appropriate handling by our system.

4 Connectivity with the Payer / Communications

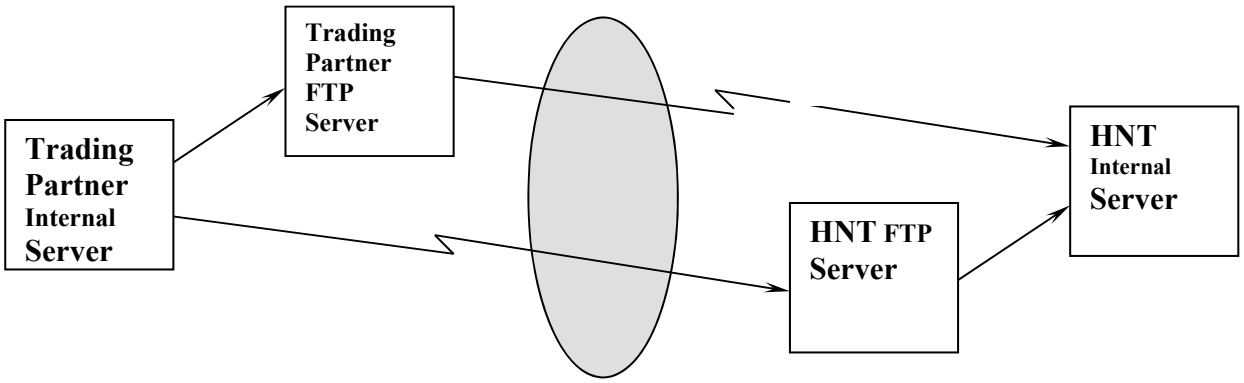
4.1 Process flows

Three file exchange methods are supported to enable batch data file transmission; (1) FTP of encrypted data over the Internet, (2) use of Connect: Direct (NDM) over the AT&T AGNS (formerly Advantis) SNA network, and (3) FTP over frame relay for trading partners with very high volumes.

4.1.1 FTP of Encrypted data over the Internet

One method of exchanging data files is encrypting the file, sending it over the Internet where it is then decrypted. For data inbound to HNT (see Figure 4.1), the trading partner would encrypt the data on an internal server and then transfer to either a trading partner owned FTP server or to HNT FTP server. Then, HNT will retrieve the encrypted file from either the trading partner FTP server or from HNT FTP server to an internal server where the file is decrypted and processed.

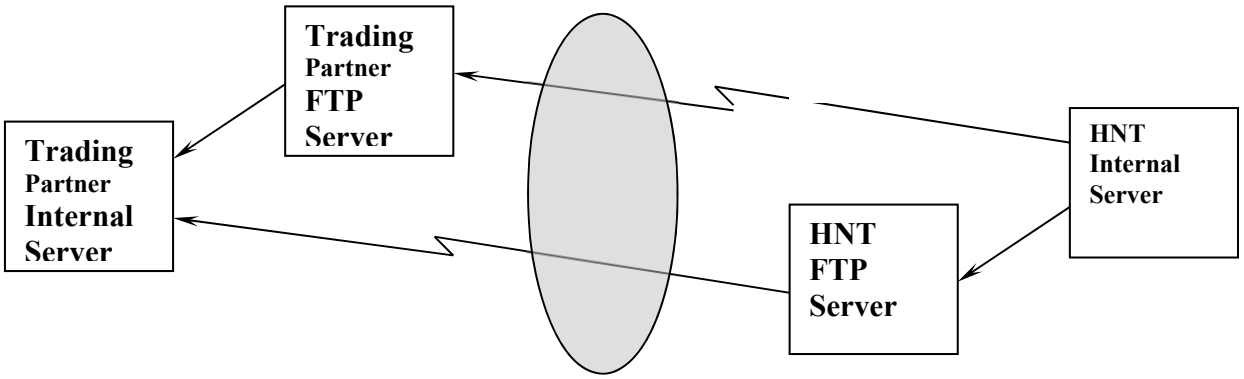
Figure 4.1.1A
FTP of Encrypted Data over the Internet from Trading Partner to HNT



For data outbound from HNT (see Figure 4.1.1B), HNT will generate the X12 data file and encrypt it. Once encrypted, the file will be sent either to HNT's FTP server or the trading partners FTP server. Then the trading partner can retrieve the file from the appropriate FTP server, transfer it to their internal system, encrypt it and process.

Figure 4.1.1B

FTP of Encrypted Data over the Internet from HNT to Trading Partner



4.1.2 Use of Connect: Direct (NDM) over the AT&T AGNS (Advantis) SNA Network

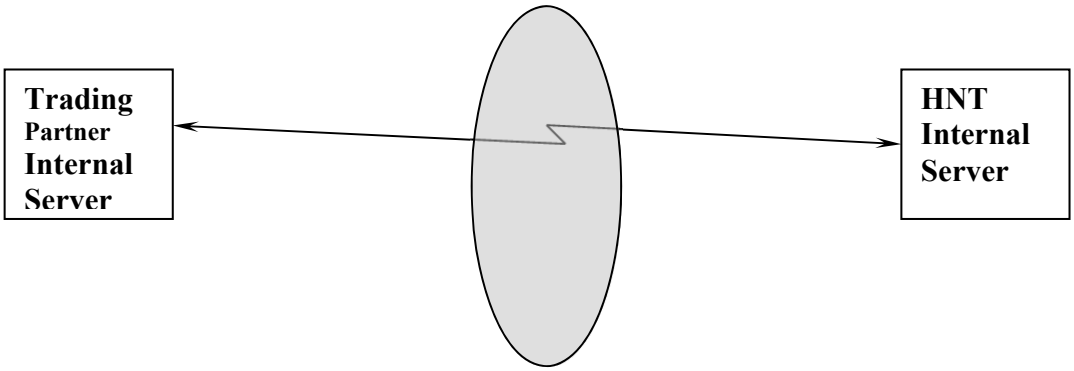
Data may also be exchanged over the AT&T AGNS (formerly Advantis) SNA network (see Figure 4.3). The transmission software must be Sterling

Commerce Connect:Direct (formerly NDM). For data inbound to HNT, the trading partner will make the data file available on their internal server. HNT will retrieve the data from the trading partner server with Connect:Direct (preferred) or the trading partner my initiate the transfer and send the data to HNT's internal server.

Data outbound from HNT takes just the opposite path with either HNT (preferred) or the trading partner initiating the file transfer.

Data transferred over the AGNS network may be encrypted or sent in clear text.

Figure 4.1.2
Connect:Direct Transfer over the AT&T AGNIS Network



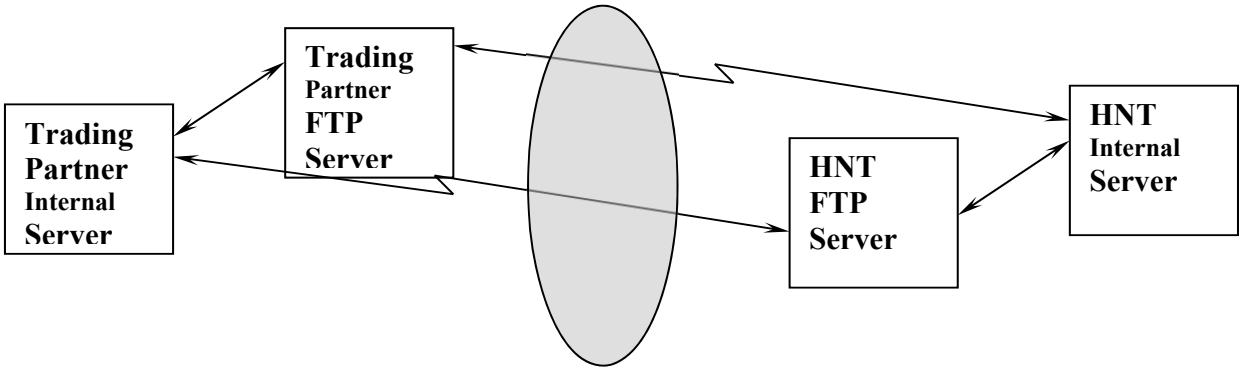
4.1.3 FTP Over Frame Relay

For trading partners with very large data volume to exchange with HNT, a private virtual circuit may be established over a frame relay link (see Figure 4.4). Once established, data will be exchanged similarly to the FTP over the Internet approach except the data will not flow over the Internet.

Data transferred over the frame relay network may be encrypted or sent in clear text.

Figure 4.1.3

FTP Over Frame Relay



4.2 Transmission Administrative Procedures

Before establishing data communications with HNT, a trading partner relationship must exist. As part of the process establishing the relationship, HNT and the trading partner must exchange certain technical information. This information is needed by both parties in order to establish communications.

The information requested will include:

1. Contacts; business, data and communications
2. Dates; testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, userID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be retransmitted, the trading partner will contact their primary contact at HNT. At that time, procedures will be followed for HNT to accept and re-transmit a file.

4.3 Communication protocol specifications

4.3.1 FTP over the Internet

The following items are required to exchange data with HNT utilizing FTP over the Internet. The trading partner is responsible for the acquisition and installation of these items. This list assumes that HNT FTP server will be used.

1. Internet Connectivity; if large files will be exchanged, then the trading partner should consider a broadband connection.
2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include confirming FTP connectivity, exchanging PGP public keys and performing end-to-end communications testing.

Before sending data to HNT, the data must be encrypted with PGP and then sent to the Health Net FTP using the FTP client over the Internet connection. When receiving data from Health Net, the FTP client will be used to get the data from the HNT FTP server after which PGP will be used to decrypt the data.

4.3.2 Connect: Direct over the AT&T AGNS Network

The following items are required to exchange data with HNT utilizing Connect: Direct (formerly NDM) over the AT&T AGNS network (formerly Advantis).

1. SNA Connectivity to the AT&T AGNS network.
2. Connect:Direct software loaded and configured on an applicable host system. HNT runs Connect:Direct on an OpenVMS system. Not all Connect:Direct versions are compatible with Connect:Direct for OpenVMS. The trading partner must confirm that their version is compatible.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Connect:Direct parameters (APPLID, LUs, etc.), submission of security requests to AT&T and end-to-end communications testing.

Using Connect:Direct, data may be “pushed” or “pulled” by either party. HNT prefers to initiate the connection. Data is exchanged when one party initiates a Connect:Direct session with the other and either “pushes” or “pulls” a file to/from the other party.

4.3.3 FTP over Frame Relay

This method of communications is only appropriate for trading partners with a very high and frequent volume. The initial setup of this method can be lengthy.

The following items are required to exchange data with HNT utilizing FTP over Frame Relay.

1. Connectivity to a Frame Relay network common with HNT.

2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Frame Relay PVC parameters and submission of a request to the frame relay carrier for connectivity. Once connectivity is established at the frame relay level, this method is similar to the FTP over the Internet method.

4.4 Passwords

HNT requires the use of UserIDs and Passwords to access its systems and servers. If HNT's FTP server is to be used to exchange data, HNT will assign each trading partner a unique UserID and Password. The UserID and other information will be communicated with the trading partner via e-mail. However, the password will be communicated via another method such as phone or fax.

In the event a trading partner forgets their password, HNT will change the password after verifying the authenticity of the request.

HNT will not utilize a trading partner owned FTP server that is not protected with a UserID and password.

4.5 Encryption

HNT requires the encryption of data that is exchanged via the Internet or any other public network. HNT utilizes PGP with 1024 or 2048 bit keys for file encryption.

5 Contact information

5.1 HNT EDI Department

HNT EDI Dept. is the central point of contact for all trading partner EDI activity including questions relating to file submissions. They will triage the issue and route EDI questions to one of three EDI areas for resolution.

Once resolution is reached, trading partners will receive a response from this same central EDI Dept.

The three areas within HNT EDI that work on EDI customer service issues are;

- HNT IT EDI Translator Team
- HNT IT Payer Connectivity and Infrastructure Team
- HNT EDI Business Operations Team

Contact Phone numbers for our HNT EDI Department:
North East and AZ: 1-866-334-4638
CA and OR: 1-800-977-3568
.

6 Control Segments / Envelopes

6.1 ISA-IEA

See Transaction Specifications, Section 10.

6.2 GS-GE

See Transaction Specifications, Section 10.

6.3 ST-SE

See Transaction Specifications, Section 10.

7 Payer Specific Business Rules and Limitations

- All monetary amounts are to include decimal points with two positions allowed to the right of the decimal point to represent cents.
- CLM segments per patient loop is limited to 100 CLM segments
- Service lines per CLM loop must be limited to 50 service lines
- Billing Provide Name Contact Information (Loop ID 2010AA) is limited to one instance.
- The following segments should **not** be sent:
  - Loop 2010AA REF - Credit/Debit Card Billing Information.
  - Loop 2010BA REF– Property and Casualty Number
  - Loop 2010BD NM1 and REF– Credit/Debit Card Holder Name and Information
  - Loop 2010CA REF– Property and Casualty Claim Number
  - Loop 2300 AMT – Credit/Debit Card Maximum

8 Acknowledgements and or Reports

997/999 and 277CA Acknowledgement will be sent so the trading partner will get confirmation that we received their 837 submission.

9 Trading Partner Agreements

Trading Partner Agreements specify the terms and conditions by which transactions are exchanged electronically with HNT.

This companion document will be an addendum to the trading partner agreement that is signed by both HNT and the trading partner with whom EDI is to be conducted.

Health Net, LLC.'s trading partner agreement is attached as an appendix to this companion document. The version of X12N that Health Net, LLC. is supporting will be identified in the trading partner agreement. As versions offered by HNT change to newer releases of X12N and adopted by HIPAA, the trading partner agreement will be amended to reflect the version changes as they occur and become required.

10 Transaction Specification Information

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
C.3	Interchange Control Header	ISA01	Authorization Information Qualifier	R	2/2	00 – No Authorization Information Present
		ISA02	Authorization Information	R	10/10	Spaces
		ISA03	Security Information Qualifier	R	2/2	00 – No Security Information Present
		ISA04	Security Information	R	10/10	Spaces
		ISA05	Interchange Sender Qualifier	R	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA06	ISA Sender ID	R	15/15	(**As agreed upon**)
		ISA07	Interchange Receiver Qualifier	R	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA08	ISA Receiver ID	R	15/15	HNT Tax ID - 954402957 (**As agreed upon**)
		ISA09	Interchange Date	R	6/6	Date of Transmission (YYMMDD)
		ISA10	Interchange Time	R	4/4	Time of Transmission (HHMM)
		ISA11	Repetition Separator	R	1/1	
		ISA12	Interchange Control Version Number	R	5/5	00501
		ISA13	ISA Control Number	R	9/9	Control number assigned by the sender, Must be identical to control number in IEA02
		ISA14	Acknowledgement Indicator	R	1/1	**1** - Send TA1, **0** - Do not send TA1
		ISA15	Usage Indicator	R	1/1	**T** - Test, **P** - Production
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
C.7	Functional Group Header	GS01	Functional Identifier Code	R	2/2	**HC** - Health Care Claim (837)
		GS02	GS Sender's Code	R	2/15	(**As agreed upon**)
		GS03	GS Receiver's Code	R	2/15	HNCA-ENC (**As agreed upon**)
		GS04	Group GS Date	R	8/8	Functional group creation date (CCYYMMDD)
		GS05	Group GS Time	R	4/8	Functional group creation time (HHMM)
		GS06	Group Control Number	R	1/9	Control number assigned by the sender
		GS07	Responsible Agency Code		1/2	**X** accredited standards committee
		GS08	Version /Release ID Code	R	1/12	005010X222A1
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
70	Transaction Set Header	ST01	Transaction Set Identifier Code	R	3/3	**837** - Health Care Claim: Professional
		ST02	Transaction Set Control Number	R	4/9	Unique control number assigned by sender's translator
		ST03	Transaction Set Version	R	1/35	Matches GS08 value

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
71	Beginning of Hierarchical Transaction	BHT01	Hierarchical Structure Code	R	4/4	**0019** (Information Source, Subscriber, Dependent)
		BHT02	Transaction Set Purpose Code	R	2/2	00 - Original 18 - Reissue
		BHT03	Originator Application Transaction Identifier	R	1/50	
		BHT04	Application Creation Date	R	8/8	CCYYMMDD
		BHT05	Application Creation Time	R	4/8	
		BHT06	Claim or Encounter Indicator	R	2/2	Identifies cap vs. fee for service claims RP - Reporting (**Encounters/ Capitation**)
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
74	1000A	NM101	Entity Identifier Code	R	1/1	**41** (Submitter)
		NM102	Entity Type Qualifier	R	1/60	**1** - person, **2** - Non-Person
		NM103	Submitter Name	R	1/60	
		NM104	Submitter First Name	S	1/35	
		NM105	Submitter Middle Name	S	1/25	
		NM106 NM107	Not Used by HIPAA			
		NM108	Identification Code	R	1/2	46 Electronic Transmitter ID Number ETIN).
		NM109	Submitter Electronic Transmitter ID	R	2/80	9-digit HNT Submitter ID **(Assign by Health Net)**
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
76	1000A	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Submitter Contact Name 1	S	1/60	
		PER04/06/08	Contact Telephone Number 1	R	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 1	R	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 1	R	1/256	**PER03,05,07=FX**
		PER04/06/08	Contact Email Address 1	R	1/256	**PER03,05,07=EM**
		PER09	Not Used by HIPAA			
		PER02	Submitter Contact Name 2	S	1/60	Used if more contact information needed. Inbound: Populated by EDI translator. Outbound: Determined by EDI Business.
		PER04/06/08	Contact Telephone Number 2	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 2	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 2	S	1/256	**PER03,05,07=FX**
		PER04/06/08	Contact Email Address 2	S	1/256	**PER03,05,07=EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

79	1000B	NM101	Entity Identifier Code	R	2/3	**40** (Receiver)
		NM102	Entity Type Qualifier	R	1/1	**2** (Non-Person Entity)
		NM103	Receiver Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**46** Electronic Transmitter ID Number (ETIN)
		NM109	Receiver Electronic Transmitter ID Number	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
83	2000A	PRV01	Provider Code	R	1/3	**BI** (Billing)
		PRV02	Reference Identification Qualifier	R	2/3	**PXC** (Provider Taxonomy Code)
		PRV03	Billing Provider Taxonomy Code	R	1/50	***(REQUIRED)***
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
84	2000A	CUR01	Entity Identifier Code	R	2/3	**85** (Billing Provider)
		CUR02	Currency Code	R	3/3	
		CUR03-CUR16	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
87	2010AA	NM101	Entity Identifier Code	R	2/3	**85** (Billing Provider)
		NM102	Entity Type Qualifier	R	1/1	1=Person 2=Organization
		NM103	Billing Provider Name	R	1/60	
		NM104	Billing Provider First Name	S	1/35	
		NM105	Billing Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Billing Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Billing Provider Primary NPI	R	2/80	**REQUIRED**
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
87	2010AA	N301	Billing Provider Address 1	R	1/55	
		N302	Billing Provider Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
92	2010AA	N401	Billing Provider City	R	2/30	
		N402	Billing Provider State	S	2/2	
		N403	Billing Provider Zip Code	S	3/15	(Nine digit zip code)
		N404	Billing Provider Country Code	S	2/3	Required only if country is not USA.

		N405 N406	Not Used by HIPAA			
		N407	Billing Provider Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
94	2010AA	REF01	Reference Identification Qualifier	**R**	2/3	**EI Employer's identification number (IRS ID number)** SY Social Security Number
		REF02	Billing Provider Taxpayer ID	R	1/50	
		REF02	Billing Provider SSN	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
96	2010AA	REF01	Reference Identification Qualifier	S	2/3	**0B** (State License Number) **1G** (Provider UPIN Number**)**
		REF02	Billing Provider Identification	S	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
98	2010AA	PER01	Contact Function Code	R	2/2	**IC** Billing provider
		PER02	Billing Provider Contact Name 1	S	1/60	
		PER04/06/08	Contact Telephone Number 1	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 1	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 1	S	1/256	**PER03,05,07 = FX**
		PER04/06/08	Contact Email Address 1	S	1/256	**PER03,05,07 = EM**
		PER09	Not Used by HIPAA			
		PER02	Billing Provider Contact Name 2	S	1/60	Used if more Billing Provider contact information needed.
		PER04/06/08	Contact Telephone Number 2	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 2	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 2	S	1/256	**PER03,05,07 = FX**
		PER04/06/08	Contact Email Address 2	S	1/256	**PER03,05,07 = EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes** **S**	**Length**	Notes/ Comments
101	2010AB	NM101	Entity Identifier Code	R	2/3	87 Pay to provider
		NM102	Entity Type Qualifier	R	1/1	1 person 2 non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

116	2000B	SBR01	Payer Responsibility Sequence Number Code	R	1/1	P - Primary S - Secondary T - Tertiary A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility 11 U - Unknown
		SBR02	Individual Relationship Code	S	2/2	Individual Relationship Code "18' - Self, if patient is subscriber. Blank otherwise
		SBR03	Insured Group or Policy Number	S	1/50	
		SBR04	Insured Group Name	S	1/60	
		SBR05	Insurance Type Code	S	1/3	12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 - Medicare Secondary ESRD Beneficiary in 12 month coordination period with employer's group health plan 14 - Medicare Secondary, No-fault Insurance including Auto as Primary 15 - Medicare Secondary Worker's Compensation 16 - Medicare Secondary PHS or Other Federal Agency 41 - Medicare Secondary Black Lung 42 - Medicare Secondary Veteran's Administration 43 - Medicare Secondary Disabled Beneficiary Under Age 65 with LGHP 47 - Medicare Secondary, Other Liability Insurance Primary
		SBR06-SBR08	Not Used by HIPAA			
		SBR09	Claim Filing Indicator Code	S	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity 16 - HMO Medicare Risk 17 - Dental Maintenance Organization AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS CI - Commercial Insurance Company DS - Disability HM - HMO FI - Federal Employees Program LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined

Page	Loop ID	Reference	Name	Codes	Length	Notes/ Comments

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
119	2000B	PAT01-PAT04	Not Used by HIPAA			
		PAT05	Date Time Period Format Qualifier	R	2/3	**D8 - Date** Applies to Subscriber, blank for dependent
		PAT06	Insured Date of Death	R	1/35	
		PAT07	Unit or Basis Measurement Code	R	2/2	**01** (Actual Pounds)
		PAT08	Insured (Patient) Weight	R	1/10	
		PAT09	Pregnancy Indicator	R	1/1	Y - Yes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
121	2010BA	NM101	Entity Identifier Code	R	2/3	**IL** Insured or Subscriber
		NM102	Entity Type Qualifier	R	1/1	1 - person, 2 – Non-Person
		NM103	Subscriber Last Name	R	1/60	
		NM104	Subscriber First Name	S	1/35	
		NM105	Subscriber Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Subscriber Name Suffix	S	1/10	
		NM108	Subscriber Primary ID	S	2/80	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use*)
		NM109	Subscriber Primary ID	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
124	2010BA	N301	Subscriber Address 1	R	1/55	
		N302	Subscriber Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
125	2010BA	N401	Subscriber City Name	R	2/30	
		N402	Subscriber State	S	2/2	
		N403	Subscriber Zip Code	S	3/15	
		N404	Subscriber Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Subscriber Sub-Country Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
127	2010BA	DMG01	Date Time Period Format Qualifier	R	2/3	**D8** Date
		DMG02	Subscriber Birth Date	R	1/35	
		DMG03	Subscriber Gender Code	R	1/1	F - Female M - Male U - Unknown
		DMG04-DMG11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
129	2010BA	REF01	Reference Identification Qualifier	R	2/3	**SY** SSN (cannot be used for Medicare)
		REF02	Subscriber SSN	R	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
130	2010BA	REF01	Reference Identification Qualifier	R	2/3	**Y4** Agency Claim Number
		REF02	Property/Casualty Agency ID number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
131	2010BA	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Property Casualty Patient Contact Name	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number	R	1/256	
		PER05	Communication Number Qualifier	R	2/2	**EX** Telephone Ext.
		PER06	Contact Telephone Extension	S	1/256	
		PER07- PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
133	2010BB	NM101	Entity Identifier Code	R	2/3	**PR** Payer
		NM102	Entity Type Qualifier	R	1/1	**2 –** Non-Person
		NM103	Payer Name	R	1/60	
		NM104- NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	Payer Primary ID XV	S	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
135	2010BB	N301	Payer Address 1	R	1/55	
		N302	Payer Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
136	2010BB	N401	Payer City Name	R	30	
		N402	Payer State	S	2	
		N403	Payer Zip Code	S	3/15	
		N404	Payer Country Code	S	3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Payer Sub-Country Code	S	3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
138	2010BB	REF01	Reference Identification Qualifier	R	2/3	**2U** Supplemental payer id number **FY** Claim office number **EI** Federal Taxpayer's ID Number
		REF02	Payer Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
140	2010BB	REF01	Reference Identification Qualifier	R	2/3	**LU** Provider Location ID Number **G2** Provider Commercial ID Number
		REF02	Billing Provider Secondary ID	R	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
144	2000C	PAT01	Dependent Relationship Code	R	2/2	01 - Spouse 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		PAT02- PAT04	Not Used by HIPAA			
		PAT06	Insured Date of Death	R	1/35	**D8** Date
		PAT08	Insured (Patient) Weight	R	1/10	**01** Actual Pounds
		PAT09	Pregnancy Indicator	R	1/1	Y - Yes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
147	2010CA	NM101	Entity Identification Code	R	2/3	**QC** Patient
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Dependent Last Name	R	1/60	
		NM104	Dependent First Name	R	1/35	
		NM105	Dependent Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Dependent Suffix Name	S	1/10	
		NM108- NM111	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
149	2010CA	N301	Dependent Address 1	R	1/55	
		N302	Dependent Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
150	2010CA	N401	Dependent City Name	R	2/30	
		N402	Dependent State	S	2/2	
		N403	Dependent Zip Code	S	3/15	
		N404	Dependent Country Code	S	2/3	Required only if country not USA.
		N405 N406	Not Used by HIPAA			
		N407	Dependent Sub-Country Code	S	2/3	Required only if country not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
152	2010CA	DMG01	Date Time Period Format Qualifier		2/3	**D8** Date
		DMG02	Dependent Birth Date	R	1/35	
		DMG03	Dependent Gender Code	R	1/1	F - Female M - Male U - Unknown (Note: Required on Outbound)
		DMG04- DMG11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
154	2010CA	REF01	Reference Identification Qualifier	R	2/3	**Y4** Property/Casualty Agency identification number
		REF02	Dependent Secondary ID Y4	R	1/50	
		REF03 REF04	Not Used by HIPAA			

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
155	2010CA	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Property Casualty Patient Contact Name	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number	R	1/256	
		PER05	Communication Number Qualifier	S	2/2	**EX** Telephone Ext.
		PER06	Contact Telephone Extension	S	1/256	
		PER07-PER09	Not Used by HIPAA		1/60	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
157	2300	CLM01	Patient Account Number	R	1/38	
		CLM02	Total Claim Charge Amount	R	1/18	
		CLM03 CLM04	Not Used by HIPAA			
		CLM05-01	Facility Type Code	R	1/2	Place of service
		CLM05-02	Facility Code Qualifier	R	1/1	**B** Claim submission reason code.
		CLM5-03	Claim Frequency Code	R	1/1	1 = Original 7 = Replacement/Adjustment 8 = Void **www.nubc.org**
		CLM06	Provider Signature Indicator	R	1/1	Y - Yes N - No
		CLM07	Provider Accept Assignment Code	S	1/1	A - Assigned B - Assignment Accepted on Clinical Lab Services Only C - Not Assigned
		CLM08	Assignment of Benefits Indicator	R	1/1	Y - Yes N - No W - Not Applicable
		CLM09	Release of Information Indicator	R	1/1	I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim
		CLM10	Patient Signature Source Code	S	1/1	P - Signature generated by provider because patient was unavailable.
		CLM11-1	Related Causes Code 1	R	2/3	AA - Auto Accident EM - Employment OA - Other Accident
		CLM11-2	Related Causes Code 2	S	2/3	AA - Auto Accident EM - Employment OA - Other Accident
		CLM11-3	Not Used by HIPAA			
		CLM11-4	Auto Accident State or Province Code	S	2/2	Auto accident state or province code
		CLM11-5	Auto Accident Country Code	S	2/3	Required only if country is not USA.
		CLM12	Special Program Indicator	S	2/3	02 - Physically Handicapped Children's Program 03 - Special Federal Funding 05 - Disability 7 Third Party Processing Delay 09 - Second Opinion or Surgery
		CLM13-CLM19	Not Used by HIPAA			

		CLM20	Delay Reason Code	S	1/2	1 - Proof of Eligibility Unknown or Unavailable 2 - Litigation, 3 - Authorization Delays 4 - Delay in Certifying Provider, 5 - Delay in Supplying Billing Forms 6 - Delay in Delivery of Custom-made Appliances 7 - Third Party Processing Delay 8 - Delay in Eligibility Determination 9 - Original Claim Rejected or Denied Due to a Reason Unrelated to Billing Limitation Rules 10 - Administration Delay in Prior Approval Process 11 Other 15 Natural Disaster
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
164-181	2300	DTP01	Onset of Current Illness or Injury Date	R	1/35	**431** Onset of Current Symptoms or Illness **454** Initial Treatment **453** Acute Manifestation **439** Accident **484** Last Menstrual Period **471** Hearing or Vision Prescription **297** Last Worked **304** Last Seen **296** Work Return **435 Hospital Admission** **096** Hospital Discharge **090** Assumed Care **091** Relinquished Care **444** Property Casualty First **050** Repricer Received **NOTE: 435 Admission required on Inpatient Claims**
		DTP02	Initial Treatment Date	R	1/35	**D8** - Date (when DTP01 = 314 or 361) or **RD8** - Date Range (when DTP01 = 314)
		DTP03	Last Seen Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
186		CN101	Contract Type Code	R	2/2	01 - Diagnosis Related Group (DRG) 02 - Per Diem 03 - Variable Per Diem 04 - Flat 05 - Capitated 06 - Percent 09 – Other
		CN102	Contract Amount	S	1/18	
		CN103	Contract Percentage	S	1/6	
		CN104	Contract Code	S	1/50	
		CN105	Terms Discount Percentage	S	1/6	
		CN106	Contract Version Identifier	S	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
188	**2300**	**AMT01**	**Amount Qualifier Code**	R	1/3	**F5** Patient Amount Paid/Responsibility
		AMT02	**Patient Amount Paid**	R	1/18	**(REQUIRED)** Monetary Amount – Patient Amount Paid/Responsibility **If Loop 2430 CAS*PR is sent. Value of all CAS*PR must match AMT*F5 Amount**
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

189-206	2300	REF01	Referencing Identification Qualifier	R	2/3	**F5** Medicare Version Code **EW** Mammography Certification **4N** Special Payment Reference **G1 (G - one)** Prior Authorization Number **9F** Referral Number **F8** Original Reference ID Number **X4** CLIA number **9C** Repricer's claim number for a previously adjusted (resubmitted) claim **9A** Repricer's claim number **D9** Clearinghouse or Value Added Network unique claim ID **1J** NPI of Home Health or Hospice Care Facility **EA** Medical Record Identification Number **P4** Project Code **LX** IDE number **NOTE: REF*F8 REQUIRED if CLM05-03 = 7 or 8**
		REF02	Reference Identification Reference Information	R	1/50	**NOTE: If F8 is sent Original Payer Claim Control Number**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
211	2300	CR102	Patient Weight	S	1/10	**LB** Pound **NOTE: Required when CLM05-01 is '41' or '42'**
		CR103	Not Used by HIPAA			
		CR104	Ambulance Transport Reason Code	R	1/1	A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transport E - Patient transferred to rehabilitation facility
		CR106	Transport Distance	R	1/15	**DH** Miles
		CR107 CR108	Not Used by HIPAA			
		CR109	Round Trip Purpose Description	S	1/80	
		CR110	Stretcher Purpose Description	S	1/80	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
214	2300	CR201-CR207	Not Used by HIPAA			
		CR208	Patient Condition Code for Spinal Manipulation	R	1/1	A - Acute Condition C - Chronic Condition D - Non-acute E - Non-Life Threatening F - Routine G - Symptomatic M - Acute Manifestation of a Chronic Condition
		CR209	Not Used by HIPAA			
		CR210	Patient Condition Description - Spinal Manipulation 1	S	1/80	

		CR211	Patient Condition Description - Spinal Manipulation 2	S	1/80	
		CR212	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
216	2300	CRC01	Code Category		2/2	**07** Certification condition code applies indicator. N No, Y Yes
		CRC02	Ambulance Certification Condition Indicator 1	R	1/1	
		CRC03	Ambulance Condition Indicator Code 1a	R	2/3	01 Patient was admitted to a hospital 04 Patient was moved by stretcher 05 Patient was unconscious or in shock 06 Patient was transported in an emergency situation 07 Patient had to be physically restrained 08 Patient had visible hemorrhaging 09 Ambulance service was medically necessary 12 Patient is confined to a bed or chair
		CRC04	Ambulance Condition Indicator Code 1b	S	2/3	See codes in CRC03 (field 48)
		CRC05	Ambulance Condition Indicator Code 1c	S	2/3	See codes in CRC03 (field 48)
		CRC06	Ambulance Condition Indicator Code 1d	S	2/3	See codes in CRC03 (field 48)
		CRC07	Ambulance Condition Indicator Code 1e	S	2/3	See codes in CRC03 (field 48)
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
219	2300	CRC01	Vision Code Category 1	R	2/2	E1 - Spectacle Lenses E2 - Contact Lenses E3 - Spectacle Frames
		CRC02	Vision Certification Condition Indicator 1	R	1/1	Y - Yes N - No
		CRC03	Vision Condition Indicator Code 1a	R	2/3	L1 - General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met L2 - Replacement Due to Loss or Theft L3 - Replacement Due to Breakage or Damage L4 - Replacement Due to Patient Preference L5 - Replacement Due to Medical Reason
		CRC04	Vision Condition Indicator Code 1b	S	2/3	See CRC03 (field 67)
		CRC05	Vision Condition Indicator Code 1c	S	2/3	See CRC03 (field 67)
		CRC06	Vision Condition Indicator Code 1d	S	2/3	See CRC03 (field 67)
		CRC07	Vision Condition Indicator Code 1e	S	2/3	See CRC03 (field 67)
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
221	2300	CRC01	Code Category	R	2/2	**75** Functional limitations
		CRC02	Homebound Certification Condition Indicator	R	1/1	
		CRC03	Homebound Indicator	R	2/3	IH - Independent at Home
		CRC04-CRC07	Not Used by HIPAA		1/1	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
221	2300	CRC01	Code Category		2/2	**ZZ** Mutually defined

		CRC02	EPSDT Certification Condition Indicator	R	1/1	Y - Yes N - No
		CRC03	EPSDT Condition Indicator Code 1	R	2/3	AV - Available - Not Used NU - Not Used S2 - Under Treatment ST - New Services Requested
		CRC04	EPSDT Condition Indicator Code 2	S	2/3	See CRC03 (field 89)
		CRC05	EPSDT Condition Indicator Code 3	S	2/3	See CRC03 (field 89)
		CRC06 CRC07	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
226	2300	HI01-1	Principal Diagnosis Qualifier	R	1/3	BK - ICD-9 ABK - ICD-10
		HI01-2	Principal Diagnosis	R	1/30	
		HI02-1	Diagnosis Qualifier 2	R	1/3	BK - ICD-9 ABK - ICD-10
		HI02-2	Diagnosis Code 2	S	1/30	
		HI03-1	Diagnosis Qualifier 3	R	1/3	BK - ICD-9 ABK - ICD-10
		HI03-2	Diagnosis Code 3	S	1/30	
		HI04-1	Diagnosis Qualifier 4	R	1/3	BK - ICD-9 ABK - ICD-10
		HI04-2	Diagnosis Code 4	S	1/30	
		HI05-1	Diagnosis Qualifier 5	R	1/3	BK - ICD-9 ABK - ICD-10
		HI05-2	Diagnosis Code 5	S	1/30	
		HI06-1	Diagnosis Qualifier 6	R	1/3	BK - ICD-9 ABK - ICD-10
		HI06-2	Diagnosis Code 6	S	1/30	
		HI07-1	Diagnosis Qualifier 7	R	1/3	BK - ICD-9 ABK - ICD-10
		HI07-2	Diagnosis Code 7	S	1/30	
		HI08-1	Diagnosis Qualifier 8	R	1/3	BK - ICD-9 ABK - ICD-10
		HI08-2	Diagnosis Code 8	S	1/30	
		HI09-1	Diagnosis Qualifier 9	R	1/3	BK - ICD-9 ABK - ICD-10
		HI09-2	Diagnosis Code 9	S	1/30	
		HI010-1	Diagnosis Qualifier 10	R	1/3	BK - ICD-9 ABK - ICD-10
		HI10-2	Diagnosis Code 10	S	1/30	
		HI011-1	Diagnosis Qualifier 11	R	1/3	BK - ICD-9 ABK - ICD-10
		HI11-2	Diagnosis Code 11	S	1/30	
		HI012-1	Diagnosis Qualifier 12	R	1/3	BK - ICD-9 ABK - ICD-10
		HI12-2	Diagnosis Code 12	S	1/30	
			Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
239	2300	HI01-2	Principal Anesthesia Related Code	S	1/30	**BP** Health Care Financing Administration Common Procedural Coding System Principal Procedure
		HI02-2	Additional Anesthesia Related Code	S	1/30	**BO** Health Care Financing Administration Common Procedural Coding System
		HI03-HI12	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
242	2300	HI01-2	Condition Indicator Code 1	S	1/30	**BG** Condition
		HI02-2	Condition Indicator Code 2	S	1/30	See HI01-2 for codes
		HI03-2	Condition Indicator Code 3	S	1/30	See HI01-2 for codes
		HI04-2	Condition Indicator Code 4	S	1/30	See HI01-2 for codes

		HI05-2	Condition Indicator Code 5	S	1/30	See HI01-2 for codes
		HI06-2	Condition Indicator Code 6	S	1/30	See HI01-2 for codes
		HI07-2	Condition Indicator Code 7	S	1/30	See HI01-2 for codes
		HI08-2	Condition Indicator Code 8	S	1/30	See HI01-2 for codes
		HI09-2	Condition Indicator Code 9	S	1/30	See HI01-2 for codes
		HI10-2	Condition Indicator Code 10	S	1/30	See HI01-2 for codes
		HI11-2	Condition Indicator Code 11	S	1/30	See HI01-2 for codes
		HI12-2	Condition Indicator Code 12	S	1/30	See HI01-2 for codes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
252	2300	HCP01	Claim Pricing/Repricing Methodology	R	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at a Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing 10 - Other Pricing 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	Claim Repricing Allowed Amount	R	1/18	
		HCP03	Claim Repricing Saving Amount	S	1/18	
		HCP04	Claim Level Repricing Organization ID	S	1/50	
		HCP05	Claim Repricing Per Diem or Flat Rate	S	1/9	
		HCP06	Claim Repricing Approved Ambulatory Patient Group Code	S	1/50	
		HCP07	Claim Repricing Approved Ambulatory Patient Group Amount	S	1/18	
		HCP08-HCP12	Not Used by HIPAA			
		HCP13	Claim Repricing Reject Reason Code	S	2/2	T1 - Cannot Identify Provider as TPO (3rd Party Organization) Participant T2 - Cannot Identify Payer as TPO Participant T3 - Cannot Identify Insured as TPO Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing T6 - Claim does not contain enough information for repricing
		HCP14	Claim Repricing Policy Compliance Code	S	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance) 3 - Not Medically Necessary (Non-Compliance) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital
		HCP15	Claim Repricing Exception Code	R	1/2	1 - Non-Network professional provider in Network hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 – Other **NOTE: REQUIRED if Known** **1 or 3 = Out of Network** **6 = In Network**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
257	2310A	NM101	Entity Identifier Code	R	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Referring Provider Last Name	R	1/60	
		NM104	Referring Provider First Name	S	1/35	
		NM105	Referring Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Referring Provider Name Suffix	S	1/10	
		NM109	Referring Provider Primary ID XX	R	2/80	**XX** NPI (HIPAA National Provider ID)
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
257	2310A	NM101	Entity Identifier Code	R	2/3	**P3** Primary Care Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	PCP Provider Last Name	R	1/60	
		NM104	PCP Provider First Name	S	1/35	
		NM105	PCP Provider Middle Name	S	1/25	
		NM107	PCP Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** NPI (HIPAA National Provider ID)
		NM109	PCP Provider Primary ID	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
260	2310A	REF01	Reference Identifier Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number (**REQUIRED**) **1G** Provider UPIN number
		REF02	Referring Provider Secondary ID	S	1/50	**REF*G2*9999 = Tribal Provider**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments** In the absence of a valid Rendering Provider Name or NPI (i.e. PA, PT, or nurse) please use the Physician Name and NPI that the services were provided under or the Physician Name and NPI that the member is assigned to.
262	**2310B**	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider **REQUIRED *if different than Billling***
		NM102	**Entity Type Qualifier**	**R**	**1/1**	**1 Person**
		NM103	**Rendering Provider Last/Organization Name**	**R**	**1/60**	
		NM104	Rendering Provider First Name	S	1/35	
		NM105	Rendering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Rendering Provider Name Suffix	S	1/10	
		NM108	**Identification Code Qualifier**	**R**	**1/2**	**XX** NPI (HIPAA National Provider ID)
		NM109	**Rendering Provider Primary ID**	**R**	**2/80**	**REQUIRED *if different than Billling***

		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
265	2310B	PRV01	Provider Code		1/3	**PE** Performing
		PRV02	Reference Identifier Qualifier		2/3	**PXC** Rendering provider specialty type
		PRV03	**Rendering Provider Taxonomy Code**	R	1/50	***REQUIRED if Rendering Provider is present***
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
267	2310B	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Rendering Provider Secondary ID G2	S	1/50	**REF*G2*9999 = Tribal Provider**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
269	2310C	NM101	Entity Identifier Code	R	2/3	**77** Service Location **NOTE: Required if Rendering Provider is present**
		NM102	Entity Type Qualifier	R	1/1	**2** (non-Person)
		NM103	Service Facility Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Facility Primary ID	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
272	2310C	N301	Service Facility Address 1	R	1/55	
		N302	Service Facility Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
273	2310C	N401	Service Facility City	R	2/30	
		N402	Service Facility State	S	2/2	
		N403	Service Facility Zip Code	S	3/15	
		N404	Service Facility Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Service Facility Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
275	2310C	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Service Facility Secondary ID	S	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
277	2310C	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Service Facility Contact Name 1	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number 1	S	1/256	
		PER05	Communication Number Qualifier	S	2/2	**EX** Telephone Ext
		PER06	Contact Telephone Extension 1	S	1/256	
		PER07- PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
280	2310D	NM101	Entity Identifier Code	R	2/3	**DQ** Referring Provider Entity Identifier Code
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Supervising Provider Last Name	R	1/60	
		NM104	Supervising Provider First Name	S	1/35	
		NM105	Supervising Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Supervising Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** NPI (HIPAA National Provider ID)
		NM109	Supervising Provider Primary ID XX	R	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
283	2310D	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Supervising Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
285	2310E	NM101	Entity Identifier Code	R	2/3	**PW** Pickup address
		NM102	Entity Type Qualifier	R	1/1	**Note: Required when CLM05-01 = '41'** **2** non-person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
287	2310E	N301	Ambulance Pickup Address 1	R	1/55	
		N302	Ambulance Pickup Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
288	2310E	N401	Ambulance Pickup City	R	2/30	
		N402	Ambulance Pickup State	R	2/2	
		N403	Ambulance Pickup Zip Code	R	3/15	
		N404	Ambulance Pickup Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Pickup Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

	2310F	NM101	Entity Identifier Code	R	2/3	**45** drop off location **Note: Required when CLM05-01 = '41'**
		NM102	Entity Type Qualifier	R	1/1	**2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
292	2310F	N301	Ambulance Drop-Off Address 1	R	1/55	
		N302	Ambulance Drop-Off Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
293	2310F	N401	Ambulance Drop-Off City	R	2/30	
		N402	Ambulance Drop-Off State	R	2/2	
		N403	Ambulance Drop-Off Zip Code	R	3/15	
		N404	Ambulance Drop-Off Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Drop-Off Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
295	2320	SBR01	Payer Responsibility Sequence Number Code	R	1/1	A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven **P - Primary** S - Secondary T - Tertiary U - Unknown **NOTE: Required to report Paid Amount and non-zero Member Cost Share in Loop 2430**
		SBR02	Individual Relationship Code	R	2/2	01 - Spouse 18 - Self 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		SBR03	Other Insured Group or Policy Number	S	1/50	
		SBR04	Other Insured Group Name	S	1/60	

		SBR05	Insurance Type Code	S	1/3	12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 - Medicare Secondary End-Stage Renal Disease Beneficiary in 12 month coordination period with employer's group health plan 14 - Medicare Secondary, No-fault Insurance including Auto as Primary 15 - Medicare Secondary Worker's Compensation 16 - Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 - Medicare Secondary Black Lung 42 - Medicare Secondary Veteran's Administration 43 - Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 - Medicare Secondary, Other Liability Insurance is Primary
		SBR06 SBR08	Not Used by HIPAA			
		SBR09	Claim Filing Indicator Code	S	1/2	11' - Other Non-Federal Programs, '12' - PPO, '13' - POS, '14' - EPO, '15' - Indemnity, '16' - HMO Medicare Risk, '17' - Dental Maintenance Organization 'AM' - Automobile Medical, 'BL' - Blue Cross/Blue Shield, 'CH' - CHAMPUS, 'CI' - Commercial Insurance Company, 'DS' - Disability, 'HM' - HMO, 'FI' - Federal Employees Program, 'LM' - Liability Medical, 'MA' - Medicare Part A, 'MB' - Medicare Part B, 'MC' - Medicaid, 'OF' - Other Federal Program, 'TV' - Title V, 'VA' - Veteran Administration Plan, 'WC' - Workers' Compensation Health Claim, 'ZZ' - Mutually Defined
Seg:	**CAS**	**Occur 5**	**Claim Level Adjustments**	**S**	**Page: 299**	
299-304	2320	CAS01	Claim Adjustment Group Code 1	R	1/2	General category of payment adjustment CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** **NOTE: Required at Loop 2430**
		CAS02	Adjustment Reason Code 1a	R	1/5	
		CAS03	Adjustment Amount 1a	R	1/18	
		CAS04	Adjustment Quantity 1a	S	1/15	
		CAS05	Adjustment Reason Code 1b	S	1/5	
		CAS06	Adjustment Amount 1b	S	1/18	
		CAS07	Adjustment Quantity 1b	S	1/15	
		CAS08	Adjustment Reason Code 1c	S	1/5	
		CAS09	Adjustment Amount 1c	S	1/18	
		CAS10	Adjustment Quantity 1c	S	1/15	
		CAS11	Adjustment Reason Code 1d	S	1/5	
		CAS12	Adjustment Amount 1d	S	1/18	
		CAS13	Adjustment Quantity 1d	S	1/15	
		CAS14	Adjustment Reason Code 1e	S	1/5	
		CAS15	Adjustment Amount 1e	S	1/18	
		CAS16	Adjustment Quantity 1e	S	1/15	

		CAS17	Adjustment Reason Code 1f	S	1/5	
		CAS18	Adjustment Amount 1f	S	1/18	
		CAS19	Adjustment Quantity 1f	S	1/15	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
305-307	2320	AMT01	Amount Qualifier Code	R	1/3	**D** Payor Amount Paid **(Required when sending SVD segment)** **EAF** Amount Owed **A8** Non-covered Charges - Actual
		AMT02	Amount	R	1/18	
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
308	2320	OI01 OI02	Not Used by HIPAA			
		OI03	Benefits Assignment Certification Indicator	R	1/1	Indicates whether insured has authorized benefits to be assigned to the provider N - No W - Not Applicable (Use when patient refuses to assign benefits) Y – Yes **(Required when sending segment)**
		OI04	Patient Signature Source Code	R	1/1	P - Signature generated by provider
		OI05	Not Used by HIPAA			
		OI06	Release of Information Code	R	1/1	Indicates whether provider has signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has signed statement perm
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
310	2320	MOA01	Reimbursement Rate	S	1/10	
		MOA02	Claim HCPCS Payable Amount	S	1/18	
		MOA03	Remittance Remark Code 1	S	1/50	
		MOA04	Remittance Remark Code 2	S	1/50	
		MOA05	Remittance Remark Code 3	S	1/50	
		MOA06	Remittance Remark Code 4	S	1/50	
		MOA07	Remittance Remark Code 5	S	1/50	
		MOA08	Claim ESRD Payment Amount	S	1/18	End Stage Renal Disease payment amount
		MOA09	Nonpayable Professional Component Amount	S	1/18	Professional component amount billed but not payable
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
313	2330A	NM101	Entity Identifier Code	R	2/3	**IL** Insured or Subscriber **(Required when sending SVD segment)**
		NM102	Entity Type Qualifier	R	1/1	**1** - person **2** - organization
		NM103	Other Insured Last Name	R	1/60	
		NM104	Other Insured First Name	S	1/35	
		NM105	Other Insured Middle Name	S	1/25	
		NM106	Not Used by HIPAA			

		NM107	Other Insured Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use)*
		NM109	Other Insured Primary ID	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
316	2330A	N301	Other Insured Address 1	R	1/55	
		N302	Other Insured Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
317	2330A	N401	Other Insured City	R	2/30	**(Required when sending SVD segment**
		N402	Other Insured State	S	2/2	
		N403	Other Insured Zip Code	S	3/15	
		N404	Other Insured Country Code	S	2/3	
		N405 N406	Not Used by HIPAA			
		N407	Other Insured Sub-Country Code	S	2/3	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
319	2330A	REF01	Reference Identification Qualifier		2/3	**SY** Social security number (cannot be used for Medicare)
		REF02	Other Insured Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
320	2330B	NM101	Entity Identifier Code	R	2/3	**PR** Payer **(Required when sending SVD segment)**
		NM102	Entity Type Qualifier	R	1/1	**2** Non-Person Entity
		NM103	Other Payer Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	½	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	Other Payer Primary ID 2	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
322	2330B	N301	Other Payer Address 1	R	1/55	
		N302	Other Payer Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
323	2330B	N401	Other Payer City	R	2/30	
		N402	Other Payer State	S	2/2	
		N403	Other Payer Zip Code	S	3/15	
		N404	Other Payer Country Code	S	2/3	
		N405 N406	Not Used by HIPAA			
		N407	Other Payer Sub-Country Code	S	2/3	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

325	2330B	DTP01	Date/Time Qualifier	R	3/3	**573** Date Claim paid
		DTP02	Date Time Period Format Qualifier	R	2/3	**D8** Date Expressed in Format CCYYMMDD
		DTP03	Other Payer Adjudication or Payment Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
326	2330B	REF01	Reference Identification Qualifier	R	2/3	**2U** Payer identification number **FY** Claim office number **EI** Tax ID
		REF02	Other Payer Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
328	2330B	REF01	Reference Identification Qualifier	R	2/3	**G1** Prior Authorization Number **9F** Referral number **T4** Adjustment Indicator **F8** Original reference number
		REF02	Other Payer Control ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
332	2330C	NM101	Entity Identifier Code	R	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
334	2330C	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number
		REF02	Other Payer Referring Provider 1 Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
336	2330D	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider
		NM102	Entity Type Qualifier	R	1/1	**1** person **2** non-person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
338	2330D	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number
		REF02	Other Payer Rendering Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
340	2330E	NM101	Entity Identifier Code	R	2/3	**77** Service Location
		NM102	Entity Type Qualifier	R	1/1	**1** Person

		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
342	2330E	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Service Facility Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
340	2330F	NM101	Entity Identifier Code	R	2/3	**DQ** Supervising Physician
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
345	2330F	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Supervising Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
347	2330G	NM101	Entity Identifier	R	2/3	**85** Billing Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person **2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
349	2330G	REF01	Reference Identification Qualifier	R	2/3	**LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Billing Provider Secondary ID	R	1/50	**LU** Location Number
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
350	2400	LX01	Service Line Number	R	1/6	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
351	2400	SV101-1	Procedure Code Qualifier	R	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing (ABC) code
		SV101-2	Procedure Code	R	1/48	
		SV101-3	Procedure Code Modifier 1	S	2/2	**NOTE: 340B physician administered drug include modifier "UD' in either SV101-3, -4, -5, or -6**
		SV101-4	Procedure Code Modifier 2	S	2/2	
		SV101-5	Procedure Code Modifier 3	S	2/2	
		SV101-6	Procedure Code Modifier 4	S	2/2	
		SV101-7	Procedure Code Description	S	1/80	Additional information when procedure code does not definitively describe condition.
		SV101-8	Not Used by HIPAA			

		SV102	Line Item Charge Amount	R	1/18	Submitted charge amount (implied decimal) Note: Zero is acceptable
		SV103	Quantity Qualifier	R	2/2	MJ - Minutes UN - Unit
		SV104	Quantity	R	1/15	Number of units (floating point)
		SV105	Place of Service Code	S	1/2	
		SV106	Not Used by HIPAA			
		SV107-1	Diagnosis Code Pointer 1	R	1/2	Diagnosis code pointer
		SV107-2	Diagnosis Code Pointer 2	S	1/2	Additional diagnosis code pointer
		SV107-3	Diagnosis Code Pointer 3	S	1/2	Additional diagnosis code pointer
		SV107-4	Diagnosis Code Pointer 4	S	1/2	Additional diagnosis code pointer
		SV108	Not Used by HIPAA			
		SV109	Emergency Indicator	S	1/1	Y - Yes
		SV110	Not Used by HIPAA			
		SV111	EPSDT Indicator	S	1/1	Y - Yes
		SV112	Family Planning Indicator	S	1/1	Y - Yes
		SV113	Not Used by HIPAA			
		SV114	Not Used by HIPAA			
		SV115	Co-Pay Status Code	S	1/1	0 - Copay Exempt
		SV116-SV121	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
359	2400	SV501-1	Product/Service ID Qualifier		2/2	**HC** (HCPCS) Codes
		SV501-2	Durable Medical Equipment Procedure Code	R	1/48	
		SV501-3-SV501-8	Not Used by HIPAA			
		SV503	Length of Medical Necessity	R	1/15	**DA** Length of medical necessity in days (floating point)
		SV504	DME Rental Price	R	1/18	DME Rental Price (implied decimal)
		SV505	DME Purchase Price	R	1/18	DME Purchase Price (implied decimal)
		SV506	Rental Unit Price Indicator	R	1/1	1 - Weekly 4 - Monthly 6 - Daily
		SV507	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
362	2400	PWK01	Attachment Report Type Code	R	2/2	03 Report Justifying Treatment Beyond Utilization Guidelines 04 Drugs Administered 05 Treatment Diagnosis 06 Initial Assessment 07 Functional Goals 08 Plan of Treatment 09 Progress Report 10 Continued Treatment 11 Chemical Analysis 13 Certified Test Report 15 Justification for Admission 21 Recovery Plan A3 Allergies/Sensitivities Document A4 Autopsy Report AM Ambulance Certification AS Admission Summary B2 Prescription B3 Physician Order B4 Referral Form BR Benchmark Testing Results

						BS Baseline BT Blanket Test Results CB Chiropractic Justification CK Consent Form(s) CT Certification D2 Drug Profile Document DA Dental Models DB Durable Medical Equipment Prescription DG Diagnostic Report DJ Discharge Monitoring Report DS Discharge Summary EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) HC Health Certificate HR Health Clinic Records I5 Immunization Record IR State School Immunization Records LA Laboratory Results M1 Medical Record Attachment MT Models NN Nursing Notes OB Operative Note OC Oxygen Content Averaging Report OD Orders and Treatments Document OE Objective Physical Examination (including vital signs) Document OX Oxygen Therapy Certification OZ Support Data for Claim P4 Pathology Report P5 Patient Medical History Document PE Parenteral or Enteral Certification PN Physical Therapy Notes PO Prosthetics or Orthotic Certification PQ Paramedical Results PY Physician's Report PZ Physical Therapy Certification RB Radiology Films RR Radiology Reports RT Report of Tests and Analysis Report RX Renewable Oxygen Content Averaging Report SG Symptoms Document V5 Death Notification XP Photographs
3	PWK02	1/2	Attachment Transmission Code	R	2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only EM - Email FX - By Fax FT - File Transfer
	PWK03 PWK04		Not Used by HIPAA			
	PWK05					**AC** Attachment Control Number
4	PWK06	2/80	Attachment Control Number	S	80	
	PWK07- PWK09					

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
366	2400	PWK01	Report Type Code		2/2	
		PWK02	DMERC Attachment Transmission Code	R	1/2	AB - Previously Submitted to Payer AD - Certification Included in this Claim AF - Narrative Segment Included in this Claim AG - No Documentation is Required NS - Not Specified (Paperwork available on request at provider's site)

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
368	2400	CR101	Unit or Basis for Measurement Code		2/2	**LB** Pound
		CR102	Patient Weight	S	1/10	
		CR103				Not Used by HIPAA
		CR104	Ambulance Transport Reason Code	R	1/1	A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transport E - Patient transported to Rehabilitation Facility
		CR105	Unit or Basis for Measurement Code		2/2	**DH** Miles
		CR106	Transport Distance	R	1/15	
		CR107 CR108	Not Used by HIPAA			
		CR109	Round Trip Purpose Description	S	1/80	
		CR110	Stretcher Purpose Description	S	1/80	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
371	2400	CR301	DME Certification	S	1/1	I - Initial R - Renewal S - Revised
		CR302	Unit or Basis for Measurement Code			**MO** Months
		CR303	DME Duration	S	1/15	
		CR304 CR305	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
373	2400	CRC01	Code Category		2/2	**07** Ambulance Certification
		CRC02	Ambulance Certification Condition 1	S	1/1	Y - Yes N - No . Note: This segment can occur up to 3 times. 1st occurrence
		CRC03	Ambulance Condition Indicator 1	S	2/3	01 - Patient was admitted to a hospital 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service medically necessary 12 - Patient is confined to a bed or chair
		CRC04	Ambulance Condition Indicator 2	S	2/3	See CRC03 for list.
		CRC05	Ambulance Condition Indicator 3	S	2/3	See CRC03 for list.
		CRC06	Ambulance Condition Indicator 4	S	2/3	See CRC03 for list.
		CRC07	Ambulance Condition Indicator 5	S	2/3	See CRC03 for list.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
376	2400	CRC01	Code Category		2/2	**70** Hospice
		CRC02	Hospice Employee Indicator	S	1/1	Y - Yes N - No
		CRC03				**65** Open
		CRC04- CRC07	Not Used by HIPAA			

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
378	2400	CRC01	Code Category		2/2	**09 D**urable Medical Equipment Certification
		CRC02	DME Certification Condition	S	1/1	Y - Yes N - No
		CRC03	DME Certification Condition Indicator 1	S	2/3	38 - Certification signed by the physician is on file at the supplier's office ZV - Replacement Item
		CRC04	DME Certification Condition Indicator 2	S	2/3	38 - Certification signed by the physician is on file at the supplier's office ZV - Replacement Item
		CRC05-CRC07	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
380	2400	DTP01	Date/Time Qualifier	R	3/3	**472** Service
		DTP02	Date Time Period Format Qualifier		2/3	**D8 or RD8**
		DTP03	Service Line To Date	S	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
386	2400	DTP03	Prescription Date	R	1/35	**DTP01 = 471** Prescription **DTP02 = D8**
		DTP03	Certification Revision Date	R	1/35	**DTP01 = 607** Certification Revision **DTP02 = D8**
		DTP03	Begin Therapy Date	R	1/35	**DTP01 = 463** Begin Therapy **DTP02 = D8**
		DTP03	Last Certification Date	R	1/35	**DTP01 = 461**Last Certification **DTP02 = D8**
		DTP03	Date Last Seen	R	1/35	**DTP01 = 304** Last Seen **DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
387	2400	DTP03	Most Recent Hemoglobin or Hematocrit Date	R	1/35	Test Date. **DTP01 = 738 DTP02 = D8**
		DTP03	Most Recent Serum Creatine Date	R	1/35	Test Date. **DTP01 = 739 DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
390	2400	DTP03	Shipped Date	R	1/35	**DTP01 = 011** Shipped **DTP02 = D8**
		DTP03	Last X-Ray Date	R	1/35	**DTP01 = 455** Last X-Ray **DTP02 = D8**
		DTP03	Initial Treatment Date	R	1/35	**DTP01 = 454** Initial Treatment **DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
391-392	2400	QTY01	Quantity Qualifier		2/2	
		QTY02	Ambulance Patient Count	R	1/15	**PT** Patients
		QTY02	Obstetric Anesthesia Additional Units	R	1/15	**FL** Units
		QTY03 QTY04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
393	2400	MEA01	Test Result ID 1	R	2/2	OG - Original TR - Test Results
		MEA02	Test Result Qualifier 1	R	1/3	HT – Height R1 – Hemoglobin R2 – Hematocrit R3 - Epoetin Starting Dosage R4 - Creatinine
		MEA03	Test Result Value 1	R	1/20	
		MEA01	Test Result ID 2	R	2/2	2nd occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 2	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 2	R	1/20	
		MEA01	Test Result ID 3	R	2/2	3rd occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 3	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 3	R	1/20	

		MEA01	Test Result ID 4	R	2/2	4th occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 4	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 4	R	1/20	
		MEA01	Test Result ID 5	R	2/2	5th occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 5	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 5	R	1/20	
		MEA04-MEA12	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
395	2400	CN101	Contract Type Code	R	1/2	01 - Diagnosis Related Group (DRG) 02 - Per Diem 03 - Variable Per Diem 04 – Flat 05 – Capitated 06 – Percent 09 - Other
		CN102	Contract Amount	S	1/18	
		CN103	Contract Percentage	S	1/6	
		CN104	Contract Code	S	1/50	
		CN105	Terms Discount Percentage	S	1/6	
		CN106	Contract Version Number	S	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
397-398	2400	REF01	Reference Identification Qualifier	R	2/3	**9B** Repriced Line Item Reference Number **9D** Adjusted Repriced Line Item Reference Number
		REF02	Reference Identification	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
399	2400	REF01	Reference Identification Qualifier	R	2/3	**G1** Prior Authorization Number
		REF02	Prior Authorization Number 2	R	1/50	See first REF02 above for codes/notes.
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
401-406	2400	REF01	Reference Identification Qualifier	R	2/3	**6R** Provider Control Number **BT** Batch Number **EW** Mammography Certification Number **X4** CLIA Number **F4** CLIA Facility Certification Number
		REF02	Line Item Control Number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
407	2400	REF01		R	2/3	**9F** Referral Number
		REF02	Referral Number	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
409-410	2400	AMT01	Amount Qualifier Code	R	1/3	**T** Tax **F4** Postage Claimed
		AMT02	Postage Claimed Amount	R	1/18	
		AMT03	Not Used by HIPAA			
Page	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
415	2400	PS101	Purchased Service Provider Identifier	R	1/50	
		PS102	Purchased Service Charge Amount	R	1/18	
		PS103	Not Used by HIPAA			
416	2400	HCP01	Line Pricing/Repricing Methodology	R	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at a Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing **10 - Other Pricing** 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	**Line Repricing Allowed Amount**	R	1/18	**REQUIRED to report Service Line Allowed Amt**
		HCP03	Line Repricing Saving Amount	S	1/18	
		HCP04	Line Level Repricing Organization ID	S	1/50	
		HCP05	Line Repricing Per Diem or Flat Rate	S	1/9	
		HCP06	Line Repricing Approved Ambulatory Patient Group Code	S	1/50	
		HCP07	Line Repricing Approved Ambulatory Patient Group Amount	S	1/18	
		HCP08	Not Used by HIPAA			
		HCP09	Line Repricing Procedure Code Qualifier	S	2/2	ER - Jurisdiction Specific Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing Concepts (ABC) Codes
		HCP10	Line Repricing Procedure Code	S	1/48	
		HCP11	Line Repricing Procedure Quantity Qualifier	S	2/2	MJ - Minutes UN - Unit
		HCP12	Line Repricing Procedure Quantity	S	1/15	
		HCP13	Line Repricing Reject Reason Code	S	2/2	T1 - Cannot Identify Provider as TPO (Third Party Organization) Participant T2 - Cannot Identify Payer as TPO Participant T3 - Cannot Identify Insured as TPO Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing T6 - Claim does not contain enough information for repricing
		HCP14	Line Repricing Policy Compliance Code	S	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital

		HCP15	Line Repricing Exception Code	S	1/2	1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 - Other
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
416	2410	LIN01	Not Used by HIPAA			
		LIN03	National Drug Code or UPC	R	1/48	**N4** National Drug Code in 5-4-2 Addendum 222A1changed element name. **REQUIRED if PAD is administered by a physician not a pharmacy.**
		LIN04-LIN31				Not Used by HIPAA
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
426	2410	CTP01-CTP03	Not Used by HIPAA			
		CTP04	National Drug Unit Count	R	1/15	Quantity
		CTP05-1	Unit/Basis for Measurement	R	2/2	Basis of measurement for CTP04. F2 - International Unit GR – Gram ME – Milligram ML – Milliliter UN - Unit
		CTP05-2-CTP05-15	Not Used by HIPAA			
		CTP06-CTP11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
428	2410	REF01	Prescription Number Qualifier	R	2/3	VY - Link Sequence Number XZ - Pharmacy Prescription Number
		REF02	Prescription Number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
430	2420A	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider
		NM102	Entity Type Qualifier	R	1/1	**1 - Person** **2 - Non-Person**
		NM103	Service Line Rendering Provider Last/Organization Name	R	1/60	
		NM104	Service Line Rendering Provider First Name	S	1/35	
		NM105	Service Line Rendering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Service Line Rendering Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Rendering Provider Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
433	2420A	PRV01	Provider Code	R	1/3	**PE** Performing

		PRV02	Reference Identification Qualifier	R	2/3	**PXC** Provider Taxonomy Code
		PRV03	Service Line Rendering Provider Taxonomy Code	R	1/50	
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
434	2420A	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number **LU** Location number
		REF02	Service Line Rendering Provider Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
436	2420B	NM101	Entity Identifier Code	R	2/3	**QB** Purchase Service Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person 2 Non-Person Entity
		NM103-NM106	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Purchased Service Provider Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
439	2420B	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Service Line Purchased Service Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
441	2420C	NM101	Entity Identifier Code	R	2/3	**77** Service Facility last/organization name
		NM102	Entity Type Qualifier	R	1/1	**2** (Service Location)
		NM103	Service Line Service Facility Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Service Facility Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

444	2420C	N301	Service Facility Address 1	R	1/55	
		N302	Service Facility Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
445	2420C	N401	Service Facility City	R	2/30	
		N402	Service Facility State	S	2/2	
		N403	Service Facility Zip Code	S	3/15	
		N404	Service Facility Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Service Facility Sub-Country Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
447	2420C	REF01	Reference Identification Qualifier	R	2/3	**LU** Location Number. **G2** Provider commercial number
		REF02	Service Line Service Facility Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
449	2420D	NM101	Entity Identifier Code	R	2/3	**DQ** Supervising Physician
		NM102	Entity Type Qualifier	R	1/1	**1 -** Person
		NM103	Supervising Provider Last Name	R	1/60	
		NM104	Supervising Provider First Name	R	1/35	
		NM105	Supervising Provider Middle Name	R	1/25	
		NM106	Not Used by HIPAA			
		NM107	Supervising Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Supervising Provider Primary ID	S	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
452	2420D	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **LU** Location Number. **G2** Provider commercial number
		REF02	Supervising Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
454	2420E	NM101	Entity Identifier Code	R	2/3	**DK** Ordering Physician
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Ordering Provider Last Name	R	1/60	
		NM104	Ordering Provider First Name	R	1/35	
		NM105	Ordering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Ordering Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier		1/2	**XX** HIPAA National Provider ID
		NM109	Ordering Provider Primary ID	S	2/80	

		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
457	2420E	N301	Ordering Provider Address 1	R	1/55	
		N302	Ordering Provider Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
458	2420E	N401	Ordering Provider City	R	2/30	
		N402	Ordering Provider State	S	2/2	
		N403	Ordering Provider Zip Code	S	3/15	
		N404	Ordering Provider Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ordering Provider Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
460	2420E	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Ordering Provider Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record for REF01= G2			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
462	2420E	PER01	Contact Function Code	R		**IC**
		PER02	Ordering Provider Contact Name	S	1/60	
		PER04/06/08	Ordering Provider Telephone	S	1/80	**PER03/05/07 = TE**
		PER04/06/08	Ordering Provider Telephone Extension	S	1/80	**PER05/07 = EX**
		PER04/06/08	Ordering Provider Fax Number	S	1/80	**PER03/05/07 = FX**
		PER04/06/08	Ordering Provider Email Address	S	1/80	**PER03/05/07 = EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
465	2420F	NM101	Entity Identifier Code	S	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	S	1/1	**1** Person
		NM103	Referring Provider Last Name	S	1/60	
		NM104	Referring Provider First Name	S	1/35	
		NM105	Referring Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Referring Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier		1/2	**XX** HIPAA National Provider ID
		NM109	Referring Provider Primary ID XX	S	1/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
468	2420F	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Referring Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record for REF01= G2			COB Data.

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
465	2420F	NM101	Entity Identifier Code	R	2/3	**P3** Primary Care Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person. If not the primary care provider, this is the initial referring provider
		NM103	PCP Provider Last Name	S	1/60	
		NM104	PCP Provider First Name	S	1/35	
		NM105	PCP Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	PCP Provider Name Suffix	S	1/10	
		NM109	PCP Provider Primary ID XX	S	1/80	**XX** HIPAA National Provider ID
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
468	2420F	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	PCP Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
470	2420G	NM101	Entity Identifier Code		2/3	**PW** Pickup Up Address
		NM102	Entity Type Qualifier		1/1	**2** Non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
472	2420G	N301	Ambulance Pickup Address 1	R	1/55	
		N302	Ambulance Pickup Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
473	2420G	N401	Ambulance Pickup City	R	2/30	
		N402	Ambulance Pickup State	S	2/2	
		N403	Ambulance Pickup Zip Code	S	3/15	
		N404	Ambulance Pickup Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Pickup Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
475	2420H	NM101	Entity Identifier Code	R	2/3	**45** Drop off Location
		NM102	Entity Type Qualifier	R	1/1	**2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
477	2420H	N301	Ambulance Dropoff Address 1	R	1/55	
		N302	Ambulance Dropoff Address 2	S	1/55	
478	2420H	N401	Ambulance Dropoff City	R	2/30	
		N402	Ambulance Dropoff State	S	2/2	
		N403	Ambulance Dropoff Zip Code	S	3/15	
		N404	Ambulance Dropoff Country Code	S	2/3	

		N405 N406	Not Used by HIPAA			
		N407	Ambulance Dropoff Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
480	2430	SVD01	Other Payer Primary Identifier	R	2/80	Must match Loop 2330B NM109 REQUIRED to report PAID Amount
		SVD02	Service Line Paid Amount	R	1/18	Note: Zero is acceptable **NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV103 (Prof) Line Item Charge Amount. SVD02 must balance to a value greater than or equal to zero (0)**
		SVD03-1	Procedure Code Qualifier	R	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing (ABC) code
		SVD03-2	Procedure Code	R	1/48	
		SVD03-3	Procedure Code Modifier 1	S	2/2	
		SVD03-4	Procedure Code Modifier 2	S	2/2	
		SVD03-5	Procedure Code Modifier 3	S	2/2	
		SVD03-6	Procedure Code Modifier 4	S	2/2	
		SVD03-7	Procedure Code Description	S	1/80	
		SVD03-8 SVD04	Not Used by HIPAA			
		SVD05	Paid Service Unit Count	R	1/15	
		SVD06	Bundled or Unbundled Line Number	S	1/6	References the service line number which this line was bundled into.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
	2430	CAS01	Claim Adjustment Group Code	R	1/2	General category of payment adjustment: CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** NOTE: **Required to report non-zero Member Cost Share** and paid amount. When submitting Member Cost Share use code PR and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below
	2430	CAS02	Adjustment Reason Code	R	1/5	Line Adjustment Reason Code – Required Member Cost Share (PR qualifier), reason codes: **1 = Deductible Amount** **2 = Coinsurance Amount** **3 = Co-payment Amount** Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
	2430	CAS03	Monetary Amount	R	1/18	
	2430	CAS04	Quantity	S	1/5	Unit of Service
	2430	CAS05	Claim Reason Code	S	1/2	Line Adjustment Reason Code

	2430	CAS06	Monetary Amount	S	1/5	
	2430	CAS07	Quantity	S	1/5	Unit of Service
	2430	CAS08	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS09	Monetary Amount	S	1/5	
	2430	CAS10	Quantity	S	1/5	Units of service
	2430	CAS11	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS12	Monetary Amount	S	1/5	
	2430	CAS13	Quantity	S	1/5	Units of service
	2430	CAS14	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS15	Monetary Amount	S	1/5	
	2430	CAS16	Quantity	S	1/5	Units of service
	2430	CAS17	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS18	Monetary Amount	S	1/5	
	2430	CAS19	Quantity	S	1/5	Units of service
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
490	2430	DTP01	Date/Time Qualifier	R	3/3	**573** Date Claim Paid or Processed
		DTP02	Date Time Period Format Qualifier	R	2/3	**D8** Date Expressed in Format CCYYMMDD
		DTP03	Service Adjudication or Payment Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
491	2430	AMT01	Amount Qualifier Code		1/3	**EAF** (implied decimal) (Amount owed)
		AMT02	Remaining Patient Liability	R	1/18	
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
492	2440	LQ01	Form Identification Code	R	1/3	AS - Form Type Code UT - HCFA DMERC Certificate of Medical Necessity Forms
		LQ02	Form Identifier	R	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
494	2440	FRM01	Question Number/Letter	R	1/20	
		FRM02	Question Response	S	1/1	N - No W - Not Applicable Y - Yes
		FRM03	Question Response Text	S	1/50	
		FRM04	Question Response Date	S	8/8	
		FRM05	Question Response Percent	S	1/6	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
496	Transaction Set Trailer	SE01	Number of Included Segments	R	1/10	
		SE02	Transaction Set Control Number	S	4/9	

Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
C.9	Functional Group Trailer	GE01	Number of Transactional Sets Included	R	1/6	
		GE02	Group Control Number	S	1/9	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
C.10	Interchange Control Trailer	IEA01	Number of Included Functional Groups	R	1/5	
		IEA02	Interchange Control Number	S	9/9	

Appendix

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Health Net, LLC

HIPAA 837 Institutional Transaction Standard Companion Guide

Refers to the Health Care Claim: Institutional 837 Implementation Guides Based on X12 version 005010X223A2

Companion Guide Version Number: 2.0

February 22, 2019

Disclosure Statement

This Companion Guide describes the EDI requirements for the submission of CA and Arizona Encounters to Health Net. Throughout the remainder of this document Health Net will be referred to HNT to describe the All Regions of Health Net.

Preface

This Companion Document to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Health Net, LLC HNT. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
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1 Introduction

1.1 Scope

This Companion document supports the implementation of a batch processing application.

HNT will accept inbound submissions that are formatted correctly in X12 terms. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide.

HNT EDI applications will edit for these conditions and reject files that are out of compliance.

This companion document will specify everything that is necessary to conduct EDI for this standard transaction. This includes;

- Specifications on the communications link
- Specifications on the submission methods
- Specifications on the transactions

1.2 Overview

This companion guide compliments the ASC X12N implementation guide currently adopted from HIPAA. As of 2007 this companion guide has been amended to include the National Provider Identifier requirements for the 837 X12 transaction.

This companion guide will be the vehicle that HNT uses with its trading partners to further qualify the HIPAA adopted implementation guide. This companion guide is compliant with the corresponding HIPAA implementation guide in terms of data element and code sets standards and requirements.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are;

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Trading partner profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

- 837 (005010X223A2)

1.4 Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between trading partners. The computer system generating the transactions must supply complete and accurate information while the system receiving the transactions must be capable of interpreting and utilizing the information in ASC X12N format, without human intervention.

The transactions must be sent in a specific format that will allow our computer application to translate the data. Health Net LLC (HNT)

supports the standard transactions adopted from HIPAA. HNT maintains a dedicated staff for the purpose of enabling and processing X12 EDI transmissions with its trading partners.

It is the goal of HNI to establish trading partner relationships and to conduct EDI as opposed to paper information flows whenever and wherever possible.

1.5 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.
HIPAA covered healthcare providers that choose to submit transactions electronically, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, the National Provider Identifier (NPI) is meant to be a lasting identifier, and would not change based on changes in a health care provider's name, address, ownership, membership in health plans or Healthcare Provider Taxonomy classification.
HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans (including Health Net), must use only the NPI in the primary identifier position to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

This companion guide has been updated to reflect how the NPI will be integrated in the 837 X12 transaction.

2 Getting Started

2.1 Working with Health Net, LLC

Contact HNT EDI Dept. for all EDI related customer service requests. (See contact information in section 5 below.)

There are three units within HNT that work internally to complete EDI service requests from our trading partners.

The first unit is Health Net's EDI Operations Dept. This group will serve as the trading partner's central point of contact. This group will also facilitate the implementation of trading partners through all steps of external testing.

The second unit is Health Net's Electronic File Transfer (EFT) team, an IT infrastructure group. This is a technical team that implements the communication link and ensures that trading partner to payer connectivity is established properly.

The third unit is Health Net's EDI IT Translator team. This group is responsible for our inbound and outbound X12 Translator applications.

2.2 Trading Partner Registration

To register as a trading partner with HNT the following sequence of events will take place.

1. Initial conversations are held between the trading partner and HNT.
2. Verbal agreements are reached as to the transactions that will be conducted.
3. A trading partner agreement and associated companion guides are provided and reviewed.
4. Submitter Id and Receiver Id is established for the purpose of identification.
5. Required trading partner profiling is built into our EDI translator.
6. Test files are exchanged and test runs conducted.
7. Once a brief testing phase is completed and a trading partner agreement is in place the trading partner is registered.

2.3 Certification and Testing Overview

HNT requires its trading partners to show evidence of third party certification. This is consistent with industry standard conventions that have been adopted for HIPAA Transaction and Code Sets implementation.

HNT will also show evidence of third party certification for standard transactions.

This requirement exists so that the process to test and implement a trading partner for the purpose of conducting EDI with standard transactions is a smooth and efficient process.

The complexity of X12 files when not tested and certified by a third party will cause delays in the ability to enable the X12 submissions in a production environment.

HNT wants to spend the majority of the testing period time, working with prospective trading partners on the agreed components of this companion document rather than X12 or HIPAA implementation guide syntax.

HNT will be certified from Claredi incorporating the following WEDI/SNIP levels of testing where applicable:
Level 1, Integrity Testing (X12 Syntax)
Level 2, Requirement Testing (HIPAA Implementation Guide Syntax)
Level 3, BalancingTesting (i.e. 835 claim line balancing to the claim document)
Level 4, Situation Testing (Use of Situational Segments that business relevant
Level 5, Code Sets Testing
Level 6, Product Types/Types of Service Testing (i.e. provider specialties)

3 Testing with the Payer

HNT would like to establish with the trading partner a set of scenarios that are intended for testing. This can be a high level description of the contents of the transaction. It should be a representation or cross section of the majority of conditions that will be encountered with production data from these transactions.

HNT requires testing be completed with all trading partners. The testing phase will consist of several smaller phases of testing, as appropriate.

3.1 HIPAA Compliance Testing

HNT uses an industry standard data translator, General Electric Information Systems (GEIS) now know as GXS to validate transactions meet the 6 levels of HIPAA compliance, and to translate them into an acceptable format for internal processing. The 997/999 Acknowledgement will be tested during this phase. Any issues identified during this phase of testing will have to be addressed in order for subsequent phases to continue.

3.2 Trading Partner Agreement Testing

Trading partner specific setup, as defined in either the trading partner agreement or companion guide will be verified. Generally, this will be done in conjunction with Compliance testing.

3.3 Functional and Regression Testing

Once the transactions have successfully tested through GXS and trading partner specifics, they will be processed through our internal system to ensure they are handled appropriately. Response transactions will be generated during this phase, where applicable.

3.4 Parallel Testing

Depending on the stage of the HNT implementation, a period of parallel testing may be required. This would involve sending the current proprietary transaction format, as well as, sending the same transactions in the x12 format, to our test system. This phase will allow for the comparative analysis necessary to ensure appropriate handling by our system.

4 Connectivity with the Payer / Communications

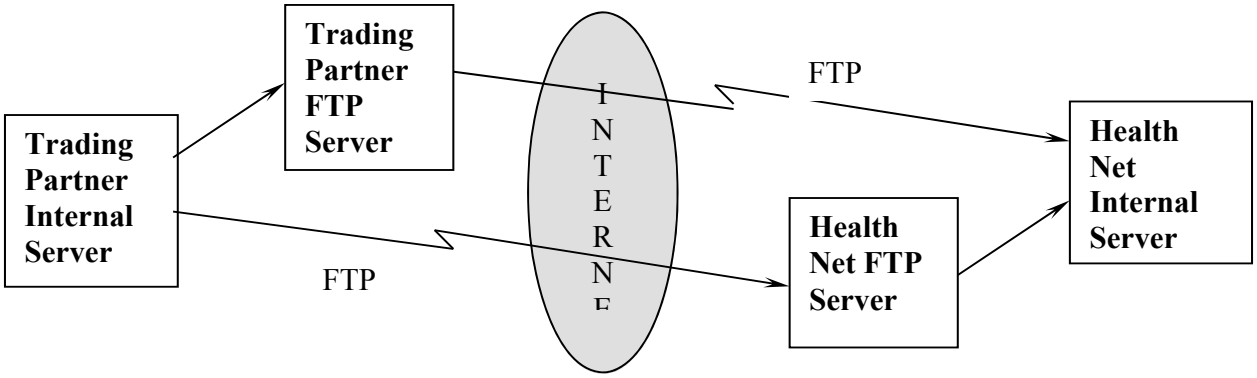
4.1 Process flows

Three file exchange methods are supported to enable batch data file transmission; (1) FTP of encrypted data over the Internet, (2) use of Connect: Direct (NDM) over the AT&T AGNS (formerly Advantis) SNA network, and (3) FTP over frame relay for trading partners with very high volumes.

4.1.1 FTP of Encrypted data over the Internet

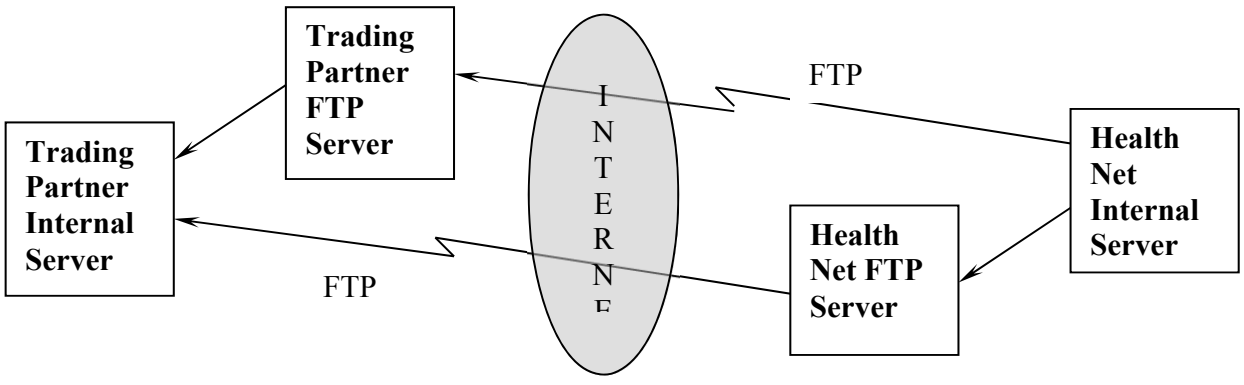
One method of exchanging data files is encrypting the file, sending it over the Internet where it is then decrypted. For data inbound to Health Net (see Figure 4.1), the trading partner would encrypted the data on an internal server and then transfer to either a trading partner owned FTP server or to Health Net's FTP server. Then, Health Net will retrieve the encrypted file from either the trading partner FTP server or from Health Net's FTP server to an internal server where the file is decrypted and processed.

Figure 4.1.1A
FTP of Encrypted Data over the Internet from Trading Partner to Health Net



For data outbound from Health Net (see Figure 4.2), Health Net will generate the X12 data file and encrypt it. Once encrypted, the file will be sent either to Health Net's FTP server or the trading partners FTP server. Then the trading partner can retrieve the file from the appropriate FTP server, transfer it to their internal system, and encrypt it and process.

Figure 4.1.1B
FTP of Encrypted Data over the Internet from Health Net to Trading Partner



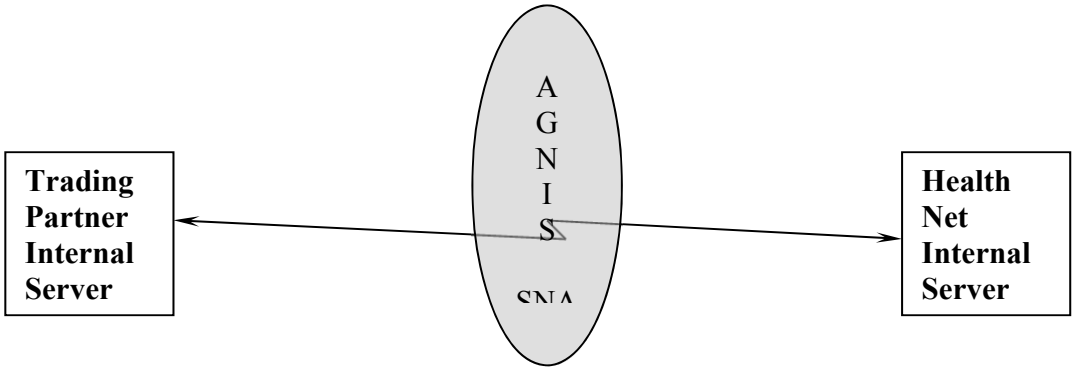
4.1.2 Use of Connect: Direct (NDM) over the AT&T AGNS (Advantis) SNA Network

Data may also be exchanged over the AT&T AGNS (formerly Advantis) SNA network (see Figure 4.3). The transmission software must Sterling Commerce Connect: Direct (formerly NDM). For data inbound to Health Net, the trading partner will make the data file available on their internal server. Health Net will retrieve the data from the trading partner server with Connect: Direct (preferred) or the trading partner my initiate the transfer and send the data to Health Net's internal server.

Data outbound from Health Net takes just the opposite path with either Health Net (preferred) or the trading partner initiating the file transfer.

Data transferred over the AGNS network may be encrypted or sent in clear text.

Figure 4.1.2
Connect: Direct Transfer over the AT&T AGNS Network

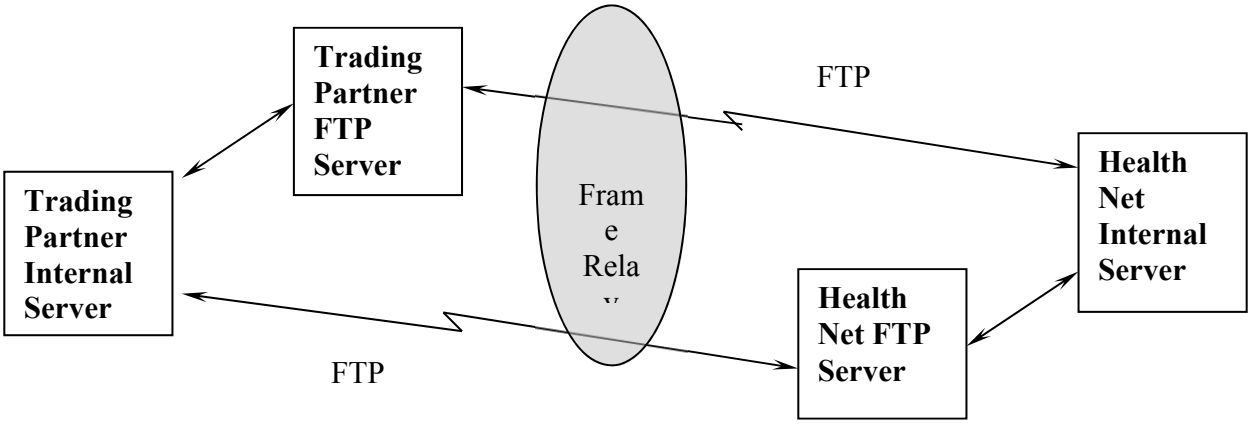


4.1.3 FTP Over Frame Relay

For trading partners with very large data volume to exchange with Health Net, a private virtual circuit may be established over a frame relay link (see Figure 4.4). Once established, data will be exchanged similarly to the FTP over the Internet approach except the data will not flow over the Internet.

Data transferred over the frame relay network may be encrypted or sent in clear text.

Figure 4.1.3
FTP Over Frame Relay



4.2 Transmission Administrative Procedures

Before establishing data communications with Health Net, a trading partner relationship must exist. As part of the process establishing the relationship, Health Net and the trading partner must exchange certain technical information. This information is needed by both parties in order to establish communications.

The information requested will include:

1. Contacts; business, data and communications
2. Dates; testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, user ID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be retransmitted, the trading partner will contact their primary contact at Health Net. At that time, procedures will be followed for Health Net to accept and re-transmit a file.

4.3 Communication protocol specifications

4.3.1 FTP over the Internet

The following items are required to exchange data with Health Net utilizing FTP over the Internet. The trading partner is responsible for the acquisition and installation of these items. This list assumes that Health Net FTP server will be used.

1. Internet Connectivity, if large files will be exchanged, then the trading partner should consider a broadband connection.
2. Computer with FTP client and connectivity to the Internet.
3. PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with Health Net via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include confirming FTP connectivity, exchanging PGP public keys and performing end-to-end communications testing.

Before sending data to Health Net, the data must be encrypted with PGP and then sent to the Health Net FTP using the FTP client over the Internet connection. When receiving data from Health Net, the FTP client will be used to get the data from the Health Net FTP server after which PGP will be used to decrypt the data.

4.3.2 Connect: Direct over the AT&T AGNS

The following items are required to exchange data with Health Net utilizing Connect: Direct (formerly NDM) over the AT&T AGNS network (formerly Advantis).

1. SNA Connectivity to the AT&T AGNS network.
2. Connect: Direct software loaded and configured on an applicable host system. Health Net runs Connect: Direct on an OpenVMS system. Not all Connect: Direct versions are compatible with Connect: Direct for OpenVMS. The trading partner must confirm that their version is compatible.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with Health Net via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Connect: Direct parameters (APPLID, LUs, etc.), submission of security requests to AT&T and end-to-end communications testing.

Using Connect: Direct, data may be “pushed” or “pulled” by either party. Health Net prefers to initiate the connection. Data is exchanged when one party initiates a Connect: Direct session with the other and either “pushes” or “pulls” a file to/from the other party.

4.3.3 FTP over Frame Relay

This method of communications is only appropriate for trading partners with a very high and frequent volume. The initial setup of this method can be lengthy.

The following items are required to exchange data with Health Net utilizing FTP over Frame Relay.

1. Connectivity to a Frame Relay network common with Health Net.
2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with Health Net via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Frame Relay PVC parameters and submission of a request to the frame relay carrier for connectivity. Once connectivity is established at the frame relay level, this method is similar to the FTP over the Internet method.

4.4 Passwords

Health Net requires the uses of UserIDs and Passwords to access it's systems and servers. If Health Net's FTP server is to be used to exchange data, Health Net will assign each trading partner a unique UserID and password. The UserID and other information will be communicated with the trading partner via e-mail. However, the password will be communicated via another method such as phone or fax.

In the event a trading partner forgets their password, Health Net will change the password after verifying the authenticity of the request.

Likely, Health Net will not utilize a trading partner owned FTP server that is not protected with a UserID and password.

4.5 Encryption

Health Net requires the encryption of data that is exchanged via the Internet or any other public network. Health Net utilizes PGP with 1024 or 2048 bit keys for file encryption.

5 Contact information

5.1 HNT EDI Department

HNT EDI Dept. is the central point of contact for all trading partner EDI activity including questions relating to file submissions. They will internally route EDI questions to one of three EDI areas for resolution.

Once resolution is reached, trading partners will receive a response from this same central EDI Dept.

The three areas within HNT EDI that work on EDI customer service issues are.

- HNT IT EDI Translator Team (EDI ITG Team)
- HNT IT Payer Connectivity and Infrastructure EFT Team
- HNT EDI Business Operations Team

Contact Phone number for EDI Dept is:
NE and AZ 1-866-334-4638
CA and OR 1-800-977-3568

6 Control Segments / Envelopes

6.1 ISA-IEA

See Section 10.

6.2 GS-GE

See Section 10.

6.3 ST-SE

See Section 10.

7 Payer Specific Business Rules and Limitations

- All monetary amounts are to include decimal points with two positions allowed to the right of the decimal point to represent cents.
- HNNE encourages the use of HNNE Group and Plan Information
- ICD-9 Procedure codes and dates are required by Health Net for all claims
- ICD-9 codes should not include the decimal point
- ICD-10 codes are not to be sent until mandated cutover date
- Condition code should be limited to a length of 5
- Treatment code and Value code should be limited to a length of 10
- Commercial Member numbers are alpha-numeric. They begin with an R or an HN. Medi-Cal members should submit the Medi-Cal ID.

8 Acknowledgements and or Reports

997/999 and 277CA Acknowledgement will be sent so the trading partner will get confirmation that we received their 837submission.

9 Trading Partner Agreements

- HNT is internally reviewing an industry standard draft for a trading partner agreement at this time.

10 Transaction Specification Information

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
C.3	Interchange Control Header	ISA01	R	Author Info Qualifier	2/2	00 – No Authorization Information Present
		ISA02	R	Author Information	10/10	Spaces
		ISA03	R	Security Info Qualifier	2/2	00 – No Security Information Present
		ISA04	R	Security Information	10/10	Spaces
		ISA05	R	Interchange Sender Qualifier	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA06	R	ISA Sender ID	15/15	(**As agreed upon**)
		ISA07	R	Interchange Receiver Qualifier	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA08	R	ISA Receiver ID	15/15	HNT Tax ID - 954402957 (**As agreed upon**)
		ISA09	R	Interchange Date	6/6	Date of Transmission (YYMMDD)
		ISA10	R	Interchange Time	4/4	Time of Transmission (HHMM)
		ISA11	R	Repetition Separator	1/1	
		ISA12	R	Interchange Control Version Number	5/5	00501
		ISA13	R	ISA Control Number	9/9	Control number assigned by the sender, Must be identical to control number in IEA02
		ISA14	R	Acknowledgement Indicator	1/1	**1** - Send TA1, **0** - Do not send TA1
		ISA15	R	Usage Indicator	1/1	**T** - Test, **P** - Production
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
C.7	Functional Group Header	GS01	R	Functional Identifier Code	2/2	**HC** - Health Care Claim (837)
		GS02	R	GS Sender's Code	2/15	(**As agreed upon**)
		GS03	R	GS Receiver's Code	2/15	HNCA-ENC (**As agreed upon**)
		GS04	R	Group GS Date	8/8	Functional group creation date (CCYYMMDD)
		GS05	R	Group GS Time	4/8	Functional group creation time (HHMM)
		GS06	R	Group Control Number	1/9	Control number assigned by the sender
		GS07	R	Responsible Agency Code		**X** Accredited Standards Committee X12

		GS08	R	Version /Release ID Code	1/12	005010X223A2
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
67	Transaction Set Header	ST01	R	Transaction Set Identifier Code	3/3	**837** Health Care Claim: Institutional
		ST02	R	Transaction Set Control Number	4/9	Unique control number assigned by sender's translator
		ST03	R	Transaction Set Version	1/35	005010X223A2
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
68	Beginning of Hierarchical Transaction	BHT01	R	Hierarchical Structure Code	4/4	**0019** Code identifying the purpose of a transaction set
		BHT02	R	Transaction Set Purpose Code	2/2	00 - Original 18 - Reissue
		BHT03	R	Originator Application Transaction Identifier	1/50	
		BHT04	R	Application Creation Date	8/8	CCYYMMDD
		BHT05	R	Application Creation Time	4/8	
		BHT06	R	Claim or Encounter Indicator	2/2	Identifies cap vs. fee for service claims RP - Reporting (**Encounters/ Capitation**)
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
71	1000A	NM101	R	Entity Identifier Code	2/3	**41 Submitter**
		NM102	R	Entity Type Qualifier	1/1	**1** person **2** non-person
		NM103	R	Submitter Name	1/60	
		NM104	S	Submitter First Name	1/35	
		NM105	S	Submitter Middle Name	1/25	
		NM106 NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	**46** Electronic Transmitter ID Number (ETIN).
		NM109	R	Submitter Identifier	2/80	9-digit HNT Submitter ID (**Assign by Health Net**)
		NM110- NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
73	1000A	PER01	R	Contact Function Code	2/2	**IC** Inbound
		PER02	S	Submitter Contact Name 1	1/60	
		PER04/06/08	R	Contact Telephone Number 1	1/256	**PER03,05,07=TE**
		PER06/08	R	Contact Telephone Extension 2	1/256	**PER05,07=EX**
		PER04/06/08	R	Contact Fax number 1	1/256	**PER03,05,07=FX**
		PER04/06/0	R	Contact Email Address 1	1/256	**PER03,05,07=EM**

		8				
		PER02	S	Submitter Contact Name 2	1/60	**IC** Used if more contact information needed.
		PER04/06/08	S	Contact Telephone Number 2	1/256	**PER03,05,07=TE**
		PER06/08	S	Contact Telephone Extension 2	1/256	**PER05,07=EX**
		PER04/06/08	S	Contact Fax number 2	1/256	**PER03,05,07=FX**
		PER04/06/08	S	Contact Email Address 2	1/256	**PER03,05,07=EM**
		PER09				Not Used by HIPAA
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
76	1000B	NM101	R	Entity Identifier Code	2/3	**40** Receiver
		NM102	R	Entity Type Qualifier	1/1	**2** Non-Person
		NM103	R	Receiver Name	1/60	
		NM104-NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	**46** Electronic Transmitter ID Number (ETIN).
		NM109	R	Receiver Identifier	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
78	2000A	HL01	R	Hierarchical ID Number	1/12	
		HL02	R	Hierarchical Parent ID Number	1/12	
		HL03		Hierarchical Level Code	1/2	20 – Information Source
		HL04		Hierarchical Child Code	1/1	1 – Additional Subordinate
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
80	2000A	PRV01	R	Provider Code	1/3	**BI** Billing
		PRV02	R	Reference Identification Qualifier	2/3	**PXC** Provider Taxonomy Code
		PRV03	R	Billing Provider Taxonomy Code	1/50	
		PRV04-PRV06		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
81	2000A	CUR01	R	Entitiy Identifier Code	2/3	**B5** currency for Billing provider
		CUR02	R	Currency Code	3/3	
		CUR03-CUR21		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
84	2010AA	NM101	R	Entitiy Identifier Code	2/3	**85** Billing Provider
		NM102	R	Entity Type Qualifier	1/1	**2** Organization
		NM103	**R**	Billing Provider Name	1/60	

		NM104-NM107		Not Used by HIPAA		
		NM108	**R**	Identification Code Qualifier	1/2	**XX** HIPAA National Provider ID
		NM109	**R**	Billing Provider Primary ID XX	2/80	**REQUIRED**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
87	2010AA	N301	R	Billing Provider Address 1	1/55	
		N302	S	Billing Provider Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
88	2010AA	N401	R	Billing Provider City	2/30	
		N402	R	Billing Provider State	2/2	
		N403	R	Billing Provider Zip Code	3/15	Nine digit Zip Code
		N404	S	Billing Provider Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Billing Provider Sub Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code** **S**	**Name**	**Length**	Notes/Comments
90	2010AA	REF01	R	Reference Identification Qualifier	2/3	**EI** Employer's identification number
		REF02	R	Billing Provider Secondary ID **EI**	1/50	**REQUIRED**
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
91	2010AA	PER01	R	Contact Function Code		**IC** Informtion Contact
		PER02	S	Billing Provider Contact Name 1	1/60	
		PER04/06/08	S	Contact Telephone Number 1	1/256	**PER03,05,07 = TE**
		PER06/08	S	Contact Telephone Extension 1	1/256	**PER05,07 = EX**
		PER04/06/08	S	Contact Fax Number 1	1/256	**PER03,05,07 = FX**
		PER04/06/08	S	Contact Email Address 1	1/256	**PER03,05,07 = EM**
		PER02	S	Billing Provider Contact Name 2	1/60	**IC** Used if more Billing Provider contact
		PER04/06/08	S	ContactTelephone Number 2	1/256	**PER03,05,07 = TE**
		PER06/08	S	ContactTelephone Extension 2	1/256	**PER05,07 = EX**
		PER04/06/08	S	Contact Fax Number 2	1/256	**PER03,05,07 = FX**
		PER04/06/08	S	Contact Email Address 2	1/256	**PER03,05,07 = EM**
		PER09		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code** **S**	**Name**	**Length**	Notes/Comments
94	2010AB	NM101	R	Entity Identifier Code	2/3	**87** Pay-to Provider

		NM102	R	Entity Type Qualifier	1/1	**2** Organization
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
107	2000B	NL01		Hierarchical ID Number	1/12	
		HL02		Hierarchical Parent ID Number	1/12	
		HL03		Hierarchical Level Code	1/2	22 – Subscriber
		HL04		Hierarchical Child Code	1/1	0 – No Subordinate 1 – Additional Subordinate
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
109	2000B	SBR01	R	Payer Responsibility Sequence Number Code	1/1	COB Payment Sequence Indicator P - Primary S - Secondary T - Tertiary A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven U - Unknown
		SBR02	S	Individual Relationship Code	2/2	Individual Relationship Code 18 - Self, if patient is subscriber. Blank otherwise
		SBR03	S	Insured Group or Policy Number	1/30	Subscriber's group number
		SBR04	S	Insured Group Name	1/60	Subscriber's group name
		SBR05-SBR08		Not Used by HIPAA		
		SBR09	S	Claim Filing Indicator Code	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity 16 - HMO Medicare Risk AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS CI - Commercial Insurance Company DS - Disability HM - HMO LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined
`Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
112	2010BA	NM101	R	Entity Identifier Code	2/3	**IL** Insured or Subscriber
		NM102	R	Entity Type Code	1/1	**1** (person) **2** (non-person)

		NM103	R	Subscriber Last Name	1/60	
		NM104	S	Subscriber First Name	1/35	
		NM105	S	Subscriber Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Subscriber Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	½	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use)*
		NM109	R	Subscriber Primary ID	2/80	HN Member ID or Medi-Cal ID
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
115	2010BA	N301	R	Subscriber Address 1	1/55	
		N302	S	Subscriber Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
116	2010BA	N401	R	Subscriber City Name	2/30	
		N402	S	Subscriber State	2/2	
		N403	S	Subscriber Zip Code	3/15	
		N404	S	Subscriber Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Subscriber Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
118	2010BA	DMG01	R	Date Time Period Format Qualifier	2/3	**D8** Date
		DMG02	R	Subscriber Birth Date	1/35	
		DMG03	R	Subscriber Gender Code	1/1	F - Female M - Male U - Unknown
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
120	2010BA	REF01	R	Reference Identification Qualifer	2/3	**SY** Social security number (cannot be used for Medicare)
		REF02	R	Subscriber Secondary ID SY	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
121	2010BA	REF01	R	Reference Identification Qualifier	2/3	**Y4** Property/Casualty Agency identification number
		REF02	R	Subscriber Secondary ID Y4	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
122	2010BB	NM101	R	Entity Identifier Code	2/3	**PR** Payer
		NM102	R	Entity Type Qualifer	1/1	**2** Non-Person Entity
		NM103	R	Payer Name	1/60	Health Net of CA, Healthnet of Arizona, (based on payer id)

		NM104-NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	R	Payer Primary ID	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
124	2010BB	N301	R	Payer Address 1	1/55	
		N301	S	Payer Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
125	2010BB	N401	R	Payer City Name	2/30	
		N402	S	Payer State	2/2	
		N403	S	Payer Zip Code	3/15	
		N404	S	Payer Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Payer Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
127	2010BB	REF01	R	Reference Identification Qualifier	2/3	**2U** Supplemental payer id number **FY** Claim office number **EI** Federal Taxpayer's ID Number
		REF02	R	Payer Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
129		REF01	R	Reference Identification Qualifier	1/50	**LU** Provider Location ID Number **G2** Provider Commercial ID Number
		REF02	R	Billing Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
131	2000C	HL01		Hierarchical ID Number	1/12	
		HL02		Hierarchical Parent ID Number	1/12	
		HL03		Hierarchical Level Code	1/2	23 - Dependent
		HL04		Hierarchical Child Code	1/1	0 – No Subordinate
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
133	2000C	PAT01	R	Dependent Relationship Code	2/2	01 - Spouse 03 - Father or Mother Stepson or Stepdaugher 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship

		PAT02-PAT09		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
135	2001CA	NM101	R	Entity Qualifier Code	2/3	**QC** Patient
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Dependent Last Name	1/60	
		NM104	R	Dependent First Name	1/35	
		NM105	S	Dependent Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Dependent Suffix Name	1/10	
		NM108-NM111		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
137	2010CA	N301	R	Dependent Address 1	1/55	
		N302	S	Dependent Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
138	2010CA	N401	R	Dependent City Name	2/30	
		N402	R	Dependent State	2/2	
		N403	R	Dependent Zip Code	3/15	
		N404	S	Dependent Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Dependent Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
140	2010CA	DMG01	R	Date Time Period Format Qualifier	2/3	**D8** Date
		DMG02	R	Dependent Birth Date	1/35	
		DMG03	R	Dependent Gender Code	1/1	F - Female M - Male U - Unknown
		DMG04-DMG11		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
142	2010CA	REF01	R	Reference Identification Qualifer	2/3	**Y4** Property/Casualty Agency identification number
		REF02	R	Dependent Secondary ID Y4	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
142	2010CA	REF01	R	Reference Identification Qualifer	2/3	**1W** Property/Casualty Patient Identifier **SY** Property/Casualty Patient Identifier
		REF02	R	Patient Identifier ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
143	2300	CLM01	R	Patient Account Number	1/38	Patient account number assigned by submitter's system

		CLM02	R	Total Claim Charge Amount	1/18	
		CLM03 CLM04		Not Used by HIPAA		
		CLM05-1	R	Facility Type Code	1/2	1st and 2nd positions of Uniform Bill Type code. CLM05-2 Always 'A'
		CLM05-3	R	Claim Frequency Code	1/1	3rd position of Uniform Bill Type code 1 = Admit thru Discharge 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 6 = Adjustment 7 = Repalcement 8 = Void **NOTE: REF*F8 is required if 3, 4, 5, 6,7, or 8**
		CLM06		Not Used by HIPAA		
		CLM07	S	Provider Accept Assignment Code	1/1	Indicates whether provider accepts assignment. A - Assigned B – Assignment Accepted on Clinical Lab Services Only C - Not Assigned
		CLM08	R	Assignment of Benefits Indicator	1/1	Indicates whether insured has authorized benefits to be assigned to the provider Y - Yes N - No W - Not Applicable
		CLM09	R	Release of Information Indicator	1/1	Indicates whether the provider has a signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim
		CLM10- CLM19		Not Used by HIPAA		
		CLM20	S	Delay Reason Code	1/2	1 - Proof of Eligibility Unknown or Unavailable 2 - Litigation, 3 - Authorization Delays 4 - Delay in Certifying Provider, 5 - Delay in Supplying Billing Forms 6 - Delay in Delivery of Custom-made Appliances 7 - Third Party Processing Delay, 8 - Delay in Eligibility Determination 9 - Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules 10 - Administration Delay in the Prior Approval Process 11 - Other 15 - Natural Disaster
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
149	2300	DTP01	R	Date/Time Qualifier	3/3	096 - Discharge
		DTP02	R	Date Time Period Format Qualifier	2/3	TM
		DTP03	R	Discharge Hour	1/35	**096** Time patient was discharged

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
150	2300	DTP01	R	Date/Time Qualifier	3/3	**434** Statement
		DTP02	R	Date Time Period Format Qualifier	2/3	**RD8** Date Range
		DTP03	S	Date Time Period	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
151	2300	DTP01	R	Date/Time Qualifier	3/3	**435** Admission
		DTP03	R	Date Time Period Format Qualifier	1/35	**D8** Date or **DT** Date + Time
		DTP03	S	Date Time Period	1/35	**Required on Inpatient**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
152	2300	DTP01	R	Date/Time Qualifier		**050** Received
		DTP02	R	Date Time Period Format Qualifier		**D8** Date
		DTP03	R	Repricer Received Date	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
153	2300	CL101	R	Priority (Type) of Admission or Visit	1/1	Addendum 223A2 changed usage from S to R and element name
		CL102	S	Point of Origin for Admission or Visit	1/1	Addendum 223A2 changed element name
		CL103	R	Patient Status Code	1/2	
		CL104		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
154	2300	PWK01	R	Attachment Report Type Code	2/2	61 possible codes. See code list on pages 183-184 of HIPAA Guidelines.
		PWK02	R	Attachment Transmission Code	1/2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only (X12 275) EM - Email FX - By Fax
		PWK03 PWK04		Not Used by HIPAA		
		PWK05		Identification Code Qualifier	1/2	**AC** Attachment Control Number
		PWK06	S	Attachment Control Number	2/80	
		PWK07- PWK09		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
158	2300	CN101	R	Contract Type Code	2/2	01 - DRG 02 - Per Diem 03 - Variable Per Diem 04 - Flat 05 - Capitated 06 - Percent 09 - Other
		CN102	S	Contract Amount	1/18	
		CN103	S	Contract Percentage	1/6	Allowance or charge percent
		CN104	S	Contract Code	1/50	
		CN105	S	Terms Discount Percentage	1/6	

		CN106	S	Contract Version Identifier	1/30	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
160	2300	AMT01		Amount qualifier Code	1/3	**F3 Patient Amount Paid/Responsibility**
		AMT02	R	Patient Responsibility Amount	1/18	Monetary Amount – Patient Amount Paid/Responsibility. **REQUIRED If Loop 2430 CAS*PR 1,2 or 3 is present. Value of all CAS*PR must match AMT*F3*Amount**
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
161-175	2300	REF01	R	Reference Identification Qualifier	2/3	**D9** VAN/Clearinghouse unique per claim ID **F8 ICN/DCN** **LX** IDE number **4N** Special Payment Reference Number **G4** PRO Approval Number **G1** Prior authorization number **9F** Referral number **EA** Medical record number **P4** Demonstration Project Identifier **LU** State of Record of Auto Accident. **9A** Repricer's claim number **9C** Repricer's claim number for a previously adjusted (resubmitted) claim
		REF02	R	Reference Identification Number	1/50	**NOTE: Required if CLM05-03 = 6,7, or 8 Payer Claim Control Number**
		REF03 REF04		Not Used by HIPAA		Ambulatory Patient Reference Numbers removed
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
181	2300	CRC02	R	Certification Condition Code Applies Indicator	1/1	**ZZ** Mutually Defined N - No, Y - Yes
		CRC03	R	Certification Condition Code 1	2/3	AV - Available - Not Used (Patient refused referral) NU - Not Used (Must be used when CRC02=N) S2 - Under Treatment (Patient currently under treatment for referred diagnostic or corrective health problem) ST - New Services Requested
		CRC04	S	Certification Condition Code 2	2/3	See CRC03 for expected codes.
		CRC05	S	Certification Condition Code3	2/3	See CRC03 for expected codes.
		CRC06 CRC07		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
184	2300	HI01-1	R	Principal Diagnosis Qualifier	1/3	BK - ICD-9 ABK - ICD-10
		HI01-2	R	Principal Diagnosis Code	1/30	
		HI01-3-HI01-8		Not Used by HIPAA		
		HI01-9	S	Principle Diagnosis POA Indicator	1/1	Y - Yes N - No U - Unknown W - Not Applicable 1 – Filler **Required on certain Inpatient**
		HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments

187	2300	HI01-1	R	Admitting Diagnosis Qualifier	1/3	BJ = ICD-9 ABJ= ICD-10
		HI01-2	R	Admitting Diagnosis	1/30	if present, next HI segment in loop. **Required on Inpatient**
		HI01-3-HI01-9 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
189	2300	HI01-1	R	Patient Reason for Visit Qualifier	1/3	PR=ICD-9 APR=ICD-10
		HI01-2	S	Patient Reason for Visit	1/30	**Required on Outpatient visits**
		HI01-3-HI01-9		Not Used by HIPAA		
		HI02-1	R	Patient Reason for Visit Qualifier	1/3	PR=ICD-9 APR=ICD-10
		HI02-2	S	Patient Reason for Visit	1/30	
		HI02-3-HI02-9		Not Used by HIPAA		
		HI03-1	R	Patient Reason for Visit Qualifier	1/3	PR=ICD-9 APR=ICD-10
		HI03-2	S	Patient Reason for Visit	1/30	
		HI03-3-HI03-9 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
193	2300	HI01-1	R	External Cause of Injury Qualifier - 1	1/3	BN=ICD-9 ABN=ICD-10
		HI01-2	S	External Cause of Injury Code - 1	1/30	Also known as E-Code.
		HI01-3-HI01-8		Not Used by HIPAA		
		HI01-9	S	Other Diagnosis 1 POA Indicator	1/1	N - No U - Unknown W - Not Applicable Y – Yes **Required on certain Inpatient**
		HI02-1	R	External Cause of Injury Qualifier - 2	1/3	BN=ICD-9 ABN=ICD-10
		HI02-2	S	External Cause of Injury Code - 2	1/30	Also known as E-Code.
		HI02-3-HI02-9		Not Used by HIPAA		
		HI03-1	R	External Cause of Injury Qualifier - 3	1/3	BN=ICD-9 ABN=ICD-10
		HI03-2	S	External Cause of Injury Code - 3	1/30	Also known as E-Code.
		HI03-3-HI03-8 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
218	2300	HI01-2	S	Diagnosis Related Group Code	1/30	**DR** Also known as DRG Group Code.
		HI03-3-HI03-9 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments **Segment Repeat 2**
220	2300	HI01-01 – HI12-01	R	Other Diagnosis Qualifier	1/3	Segment 1. BN=ICD-9 ABN=ICD-10
		HI01-02 – HI12-02	R	Other Diagnosis 1	1/30	

		HI01-09 - HI12-09	S	Other Diagnosis 1 POA Indicator	1/1	N - No U - Unknown W - Not Applicable Y – Yes **Required on certain Inpatient**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
239	2300	HI01-1	R	Principal Procedure Code Qualifier	1/3	BR=ICD-9 ABR=ICD-10 CAH=Advanced Billing Concepts
		HI01-2	R	Principal Procedure Code	1/30	
		HI01-4	R	Principal Procedure Date	1/35	**D8**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments **Segment Repeat 2**
242	2300	HI01-01 – HI12-01	R	Other Procedure Code 1-12 Qualifier	1/3	Segment 1. BQ=ICD-9 ABQ=ICD-10
		HI01-02 – HI12-02	R	Other Procedure Code 1-12	1/30	Additional procedure
		HI01-03 – HI12-03	R	Other Procedure 1-12 Date	1/35	**D8**
		HI01-04 – HI12-04	R	Date Time Period	8	**CCYYMMDD**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
258	2300	HI01 - 2	R	Occurrence Span Code - 1	1/30	Segment 1. **BI** Occurrence Span
		HI01 - 4	R	Occurrence Span From Date - 1	1/35	**RD8** Date Range
		HI01 - 4	R	Occurrence Span To Date - 1	1/35	
		HI02 - 2	S	Occurrence Span Code - 2	1/30	**BI** Occurrence Span
		HI02 - 4	S	Occurrence Span From Date - 2	1/35	**RD8** Date Range
		HI02 - 4	S	Occurrence Span To Date - 2	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
271	2300	HI01 - 2	R	Occurence Code 1	1/30	Segment 1. **BH** Occurrence
		HI01 - 4	R	Occurrence Code Date 1	1/35	**D8** Date
		HI02 - 2	S	Occurence Code 2	1/30	**BH** Occurrence
		HI02 - 4	S	Occurrence Code Date 2	1/35	**D8** Date
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
284	2300	HI01 - 2	R	Value Code-1	1/30	**BE** Value
		HI01 - 5	R	Value Code Amount-1	1/18	
		HI02 - 2	S	Value Code-2	1/30	**BE** Value
		HI02- 5	S	Value Code Amount-2	1/18	
		HI03 - 2	S	Value Code-3	1/30	**BE** Value
		HI03- 5	S	Value Code Amount-3	1/18	
		HI04 - 2	S	Value Code-4	1/30	**BE** Value
		HI04- 5	S	Value Code Amount-4	1/18	
		HI05 - 2	S	Value Code-5	1/30	**BE** Value
		HI05- 5	S	Value Code Amount-5	1/18	
		HI06 - 2	S	Value Code-6	1/30	**BE** Value
		HI06- 5	S	Value Code Amount-6	1/18	
		HI07 - 2	S	Value Code-7	1/30	**BE** Value
		HI07- 5	S	Value Code Amount-7	1/18	
		HI08 - 2	S	Value Code-8	1/30	**BE** Value
		HI08- 5	S	Value Code Amount-8	1/18	
		HI09 - 2	S	Value Code-9	1/30	**BE** Value
		HI09- 5	S	Value Code Amount-9	1/18	
		HI10 - 2	S	Value Code-10	1/30	**BE** Value
		HI10- 5	S	Value Code Amount-10	1/18	
		HI11 - 2	S	Value Code-11	1/30	**BE** Value
		HI11- 5	S	Value Code Amount-11	1/18	

		HI12 - 2	S	Value Code-12	1/30	**BE** Value
		HI12- 5	S	Value Code Amount-12	1/18	
		HIxx-3 HIxx-4 Hixx-6- HIxx-9		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
294	2300	HI01 - 2	R	Condition Code 1	1/30	Segment 1 **BG** Condition
		HI02 - 2	S	Condition Code 2	1/30	**BG** Condition
		HI03 - 2	S	Condition Code 3	1/30	**BG** Condition
		HI04 - 2	S	Condition Code 4	1/30	**BG** Condition
		HI05 - 2	S	Condition Code 5	1/30	**BG** Condition
		HI06 - 2	S	Condition Code 6	1/30	**BG** Condition
		HI07 - 2	S	Condition Code 7	1/30	**BG** Condition
		HI08 - 2	S	Condition Code 8	1/30	**BG** Condition
		HI09 - 2	S	Condition Code 9	1/30	**BG** Condition
		HI10 - 2	S	Condition Code 10	1/30	**BG** Condition
		HI11 - 2	S	Condition Code 11	1/30	**BG** Condition
		HI12 - 2	S	Condition Code 12	1/30	**BG** Condition
		HIxx-3- HIxx-9		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
304	2300	HI01 - 2	R	Treatment Code 1	1/30	Segment 1. **TC** Treatment Codes
		HI02 - 2	S	Treatment Code 2	1/30	**TC** Treatment Codes
		HI03 - 2	S	Treatment Code 3	1/30	**TC** Treatment Codes
		HI04 - 2	S	Treatment Code 4	1/30	**TC** Treatment Codes
		HI05 - 2	S	Treatment Code 5	1/30	**TC** Treatment Codes
		HI06 - 2	S	Treatment Code 6	1/30	**TC** Treatment Codes
		HI07 - 2	S	Treatment Code 7	1/30	**TC** Treatment Codes
		HI08 - 2	S	Treatment Code 8	1/30	**TC** Treatment Codes
		HI09 - 2	S	Treatment Code 9	1/30	**TC** Treatment Codes
		HI10 - 2	S	Treatment Code 10	1/30	**TC** Treatment Codes
		HI11 - 2	S	Treatment Code 11	1/30	**TC** Treatment Codes
		HI12 - 2	S	Treatment Code 12	1/30	**TC** Treatment Codes
		HIxx-3- HIxx-9		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
313	2300	HCP01	R	Claim Pricing/Repricing Methodology	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing 10 - Other Pricing 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	R	Claim Repricing Allowed Amount	1/18	

		HCP03	S	Claim Repricing Saving Amount	1/18	
		HCP04	S	Claim Level Repricing Organization ID	1/50	
		HCP05	S	Claim Repricing Per Diem or Flat Rate	1/9	
		HCP06	S	Claim Repricing Approved Ambulatory Patient Group Code	1/50	
		HCP07	S	Claim Repricing Approved Ambulatory Patient Group Amount	1/18	
		HCP08	S	Claim Repricing Approved Revenue Code	1/48	
		HCP09 HCP10		Not Used by HIPAA		
		HCP11	S	Claim Repricing Quantity Qualifier	2/2	Codes: DA - Days UN - Units Qualifies the basis for measurement represented in the HCP12 Quantity field.
		HCP12	S	Claim Repricing Approved Quantity	1/15	
		HCP13	S	Claim Repricing Reject Reason Code	2/2	T1 - Cannot identify provider as TPO participant T2 - Cannot identify payer as TPO participant T3 - Cannot identify insured as TPO participant T4 - Payer name or identifier missing T5 - Certification information missing T6 - Claim does not con
		HCP14	S	Claim Repricing Policy Compliance Code	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Net
		HCP15	S	Claim Repricing Exception Code	1/2	Exception reason for consideration of out-of-network services 1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 – Other **Required if known** **1 or 3 = Out of Network** **6 = In Network**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
319	2310A	NM101		Entity Identifier Code	2/3	**71** Attending Physician **Required when contains any service other than non-scheduled transportation**
		NM102		Entity Type Code	1/1	**1** Person
		NM103	R	Claim Attending Physician Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Attending Physician First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Attending Physician Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Attending Physician Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	**XX** National Provider **Required**
		NM109	R	Attending Physician Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110- NM112		Not Used by HIPAA		

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
322	2310A	PRV01		Provider Code	1/3	**AT** Attending physician specialty type
		PRV02	R	Reference Identification Qualifier	2/3	**PXC** Provider Taxonomy Code
		PRV03	R	Attending Physician Taxonomy Code	1/50	**REQUIRED If loop is sent**
		PRV04-PRV06		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
	REF	**S**	**Occur 4**	**Attending Provider Secondary Identification**	**Page: 324**	
324	2310A	REF01	S	Reference Identification Qualifer	2/3	**1G** UPIN number **0B** State license number **LU** Location Number **G2** Provider commercial number
		REF02	S	Attending Physician Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
326	2310B	NM101	R	Entity Identifier Code	2/3	**72** Operating Physician
		NM102	R	Entity Type Code	1/1	**1=**Person **2=**Organization
		NM103	R	Operating Physician Last Name	1/60	**REQUIRED If loop is sent**
		NM104	R	Operating Physician First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Operating Physician Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Operating Physician Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	**XX** HIPAA National Provider ID
		NM109	R	Operating Physician Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
329		REF01	S	Reference Identification Qualifer	2/3	UPIN number **=1G** State license number **=0B** (zero B) Location Number **=LU** Provider commercial number **=G2**
		REF02	S	Operating Physician Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
331	2310C	NM101	R	Entity Identifier Code	2/3	**ZZ** Mutually Defined
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Other Operating Physician Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Other Operating Physician First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Other Operating Physician Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Other Operating Physician Name Suffix	1/10	

		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID=**XX**
		NM109	R	Other Operating Physician Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code S**	**Name**	**Length**	Notes/Comments
334	2310C	REF01	S	Reference Identification Qualifier	2/3	UPIN number **=1G** State license number **=0B** (Required) Location Number **=LU** Provider commercial number. **=G2**
		REF02	S	Other Operating Physician Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
336	2310D	NM101	R	Entity Identifier Code	2/3	**82** Rendering Provider **REQUIRED if different than Attending**
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Rendering Provider Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Rendering Provider First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Rendering Provider Middle Name	1/25	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX REQUIRED**
		NM109	R	Rendering Provider Primary ID XX	2/80	**REQUIRED**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code S**	**Name**	**Length**	Notes/Comments
339	2310D	REF01	**S**	Reference Identification Qualifier	2/3	UPIN number **=1G** State license number = **0B** (Required) Location Number **=LU** **Provider commercial number. =G2** **G2 Required to report Tribal Provider (REF02 = 9999)**
		REF02	S	Rendering Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
341	2310E	NM101	R	Entity Identifier Code	2/3	Service facility/Lab name **=77** **Required if different than Billing to idenitiy entity where service were preformed**
		NM102	R	Entity Type Qualifier	1/1	**2** Non-Person Entity
		NM103	R	Service Facility Name	1/60	**REQUIRED If loop is sent**
		NM104-NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX REQUIRED**
		NM109	R	Service Facility Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
344	2310E	N301	R	Service Facility Address 1	1/55	Must not be blank if loop used.
		N302	S	Service Facility Address 2	1/55	
Page	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments

#						
345	2310E	N401	R	Service Facility City	2/30	
		N402	R	Service Facility State	2/2	
		N403	R	Service Facility Zip Code	3/15	
		N404	S	Service Facility Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Service Facility Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
347	2310E	REF01	R	Reference Identification Qualifier	2/3	State license number **=0B** (zero B) Location Number **=LU** Provider commercial number. **=G2**
		REF02	R	Service Facility Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
349	2310F	NM101	R	Entity Identifier Code	2/3	**DN** Referring Provider **Required if Referred**
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Referring Provider Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Referring Provider First Name	1/35	
		NM105	S	Referring Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Referring Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX**
		NM109	R	Referring Provider Primary ID XX	2/80	**Required if Loop is sent**
		NM110- NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
352	2310F	REF01	S	Reference Identification Qualifier	2/3	UPIN number **=1G** State license number **=0B** (zero B) Provider commercial number. **=G2** **G2 Required to report Tribal Provider (REF02 = 9999)**
		REF02	S	Referring Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
354	2320	SBR01	R	Payer Responsibility Sequence Number Code	1/1	COB Payment Sequence Indicator P - Primary S - Secondary T - Tertiary A - Payer Four B - Payer Five C - Payer Six D - Payer Seven E - Payer Eight F - Payer Nine G - Payer Ten H - Payer Eleven U – Unknown **NOTE: Required to report SVD or CAS segment (paid and patient responsibility) in loop 2430**

		SBR02	R	Individual Relationship Code	2/2	01 - Spouse 18 - Self 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		SBR03	S	Other Insured Group or Policy Number	1/30	Subscriber's group number
		SBR04	S	Other Insured Group Name	1/60	Subscriber's group name
		SBR05-SBR08				Not Used by HIPAA
		SBR09	S	Claim Filing Indicator Code	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity **16 - HMO Medicare Risk** 17 - Dental HMO AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS **CI - Commercial Insurance Company** DS - Disability FI - Federal Employees Association **HM - HMO** LM - Liability Medical MA - Medicare Part A MB - Medicare Part B **MC - Medicaid** OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
358	2320	CAS01	R	Claim Adjustment Group Code 1	1/2	1st occurrence of segment. General category of payment adjustment: CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** **NOTE: Required in Loop 2430**
		CAS02	R	Adjustment Reason Code 1a	1/5	
		CAS03	R	Adjustment Amount 1a	1/18	
		CAS04	S	Adjustment Quantity 1a	1/15	

		CAS05	S	Adjustment Reason Code 1b	1/5	
		CAS06	S	Adjustment Amount 1b	1/18	
		CAS07	S	Adjustment Quantity 1b	1/15	
		CAS08	S	Adjustment Reason Code 1c	1/5	
		CAS09	S	Adjustment Amount 1c	1/18	
		CAS10	S	Adjustment Quantity 1c	1/15	
		CAS11	S	Adjustment Reason Code 1d	1/5	
		CAS12	S	Adjustment Amount 1d	1/18	
		CAS13	S	Adjustment Quantity 1d	1/15	
		CAS14	S	Adjustment Reason Code 1e	1/5	
		CAS15	S	Adjustment Amount 1e	1/18	
		CAS16	S	Adjustment Quantity 1e	1/15	
		CAS17	S	Adjustment Reason Code 1f	1/5	
		CAS18	S	Adjustment Amount 1f	1/18	
		CAS19	S	Adjustment Quantity 1f	1/15	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
364-366	2320	AMT01	R	Amount Qualifier Code	1/18	**D Payor Amount Paid** **Required when sending Loop 2430) Value must be greater than or equal to (0)** **EAF** Amount Owed **A8** Noncovered Charges - Actual
		AMT02	R	Remaining Patient Liability Amount	1/18	
		AMT02	R	Non-Covered Amount	1/18	
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
367	2320	OI01 OI02		Not Used by HIPAA		
		OI03	R	Benefits Assignment Certification Indicator	1/1	Indicates whether insured has authorized benefits to be assigned to the provider N - No Y - Yes W - patient refuses to assign benefits **(Required when sending Loop 2430)**
		OI04 OI05		Not Used by HIPAA		
		OI06	R	Release of Information Code	1/1	Indicates whether provider has signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim **(Required when sending Loop 2430)**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
369	2320	MIA01	R	Covered Days	1/15	
		MIA02		Not Used by HIPAA		Lifetime Reserve Days Count
		MIA03	S	Lifetime Psychiatric Days Count	1/15	
		MIA04	S	Claim DRG Amount	1/18	
		MIA05	S	Remittance Remark Code 1	1/50	
		MIA06	S	Claim Disproportionate Share Amount	1/18	
		MIA07	S	Claim MSP Pass-through Amount	1/18	
		MIA08	S	Claim PPS Capital Amount	1/18	
		MIA09	S	PPS-Capital FSP DRG Amount	1/18	

		MIA10	S	PPS-Capital HSP DRG Amount	1/18	
		MIA11	S	PPS-Capital DSH DRG Amount	1/18	
		MIA12	S	Old Capital Amount	1/18	
		MIA13	S	PPS-Capital IME Amount	1/18	
		MIA14	S	PPS-Operating Hospital Specific DRG Amount	1/18	
		MIA15	S	Cost Report Day Count	1/15	
		MIA16	S	PPS-Operating Federal Specific DRG Amount	1/18	
		MIA17	S	Claim PPS Capital Outlier Amount	1/18	
		MIA18	S	Claim Indirect Teaching Amount	1/18	
		MIA19	S	Nonpayable Professional Component Amount	1/18	
		MIA20	S	Remittance Remark Code 2	1/50	
		MIA21	S	Remittance Remark Code 3	1/50	
		MIA22	S	Remittance Remark Code 4	1/50	
		MIA23	S	Remittance Remark Code 5	1/50	
		MIA24	S	PPS-Capital Exception Amount	1/18	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
374	2320	MOA01	S	Reimbursement Rate	1/10	
		MOA02	S	Claim HCPCS Payable Amount	1/18	**Required to report Medicare 100% Allowable**
		MOA03	S	Remittance Remark Code 6	1/50	
		MOA04	S	Remittance Remark Code 7	1/50	
		MOA05	S	Remittance Remark Code 8	1/50	
		MOA06	S	Remittance Remark Code 9	1/50	
		MOA07	S	Remittance Remark Code 10	1/50	
		MOA08	S	Claim ESRD Payment Amount	1/18	
		MOA09	S	Nonpayable Professional Component Amount	1/18	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
377	2330A	NM101	R	Entity Identifier Code	2/3	**IL** Insured or Subscriber (**Required when sending Loop 2430)**
		NM102	R	Entity Type Qualifier	1/1	**1** person **2** organization
		NM103	R	Other Insured Last Name	1/60	
		NM104	S	Other Insured First Name	1/35	
		NM105	S	Other Insured Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Other Insured Name Suffix	1/10	
		NM108	R	Identification Code Qualifer	1/2	Member identification number **=MI** HIPAA National Individual Identifier NM108=II (future use)
		NM109	R	Other Insured Primary ID	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
380	2330A	N301	R	Other Insured Address 1	1/55	
		N302	S	Other Insured Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
381	2330A	N401	R	Other Insured City	2/30	**Required when sending Loop 2430)**

		N402	S	Other Insured State	2/2	
		N403	S	Other Insured Zip Code	3/15	
		N404	S	Other Insured Country Code	2/3	
		N405 N406		Not Used by HIPAA		
		N407	S	Other Insured Sub-Country Code	1/3	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
383	2330A	REF01	R	Reference Identification Qualifier	2/3	Social security number (cannot be used for Medicare) **=SY**
		REF02	R	Other Insured Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
384	2330B	NM101	R	Entity Identifier Code	2/3	**PR** Payer (**Required when sending Loop 2430)**
		NM102	R	Entity Type Qualifier	1/1	**2** Non-Person Entity
		NM103	R	Other Payer Name	1/60	
		NM104- NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	Payer identification number = **PI** *HCFA National Plan ID (future use)* ***=XV***
		NM109	R	Other Payer Primary ID	2/80	95568
		NM110- NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
386	2330B	N301	R	Other Payer Address 1	1/55	
		N302	S	Other Payer Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
387	2330B	N401	R	Other Payer City	2/30	**Required when sending Loop 2430)**
		N402	S	Other Payer State	2/2	
		N403	S	Other Payer Zip Code	3/15	
		N404	S	Other Payer Country Code	2/3	
		N405 N406		Not Used by HIPAA		
		N407	S	Other Payer Sub-Country Code	1/3	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
389	2330B	DTP01	R	Date/ Time Qualifier	3/3	**573** Date Claim Paid **(Required when sending Loop 2430)**
		DTP02	R	Datye Time Period Format Qualifier	2/3	**D8** Date
		DTP03	R	Other Payer Adjudication or Payment Date	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
390	2330B	REF01	R	Reference Identification Qualifier	2/3	Payer identification number **=2U** Claim office number **=FY** Tax ID **=EI**
		REF02	R	Other Payer Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
392-395	2330B	REF01	R	Reference Identifcation Qualifier	2/3	Prior Authorization Number **=G1** Referral number **=9F** Adjustment Indicator **=T4** Original reference number **=F8**
		REF02	R	Other Payer Referral Number	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
396	2330C	NM101	R	Entity Identifier Code	2/3	**71** Attending Physician
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
398	2330C	REF01	R	Reference Identification Qualifier	2/3	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Attending Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
400	2330D	NM101	R	Entity Identifier Code	2/3	**2** Operating Physician
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
402	2330D	REF01	R	Reference Identification Qualifier	2/3	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Operating Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
404	2330E	NM101	R	Entity Identifier Code	2/3	**ZZ** Mutually Defined
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
406	2330E	REF01	R	Reference Identification Qualifier	2/3	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Other Operating Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments

408	2330F	NM101	R	Entity Identifier Code	2/3	**77** Service Location
		NM102	R	Not mappedEntity Type Qualifier	1/1	**2** Non-Person Entity
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
410	2330F	REF01	R	Reference Identification Qualifier	1/50	State License Number **=0B** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Service Facility Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
412	2330G	NM101	R	Entity Identifier Code	2/3	**82** Rendering Provider
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
414	2330G	REF01	R	Reference Identification Qualifier	1/50	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Other Operating Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
416	2330H	NM101	R	Entity Identifier Code	2/3	**DN** Referring Provider
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
418	2330H	REF01	R	Reference Identification Qualifier	1/50	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2**
		REF02	R	Other Payer Referring Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
420	2330I	NM101	R	Entity Identifier Code	2/3	**85** Billing Provider
		NM102	R	Not mappedEntity Type Qualifier	1/1	**2** Non-Person Entity
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
422	2330I	REF01	R	Reference Identification Qualifier	1/50	Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Billing Provider Secondary ID	1/50	

		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
423	2400	LX01	R	Service Line Number	1/6	Service line order as transmitted.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
424	2400	SV201	R	Revenue Code	1/48	
		SV202-1	S	Procedure Code Qualifier	2/2	**HC** - CPT/HCPCS code **Required on certain Outpatient** ER - Health Insurance Prospective Payment System **HP** – HIPPS (**Required on Home Health and SNF)** IV - HIEC WK - DC-10
		SV202-2	S	Procedure Code	1/48	
		SV202-3	S	Procedure Code Modifier 1	2/2	**NOTE: 340B physician administered drug include modifier "UD' in either SV202-3, -4, -5, or -6**
		SV202-4	S	Procedure Code Modifier 2	2/2	
		SV202-5	S	Procedure Code Modifier 3	2/2	
		SV202-6	S	Procedure Code Modifier 4	2/2	
		SV202-7	S	Procedure Description	1/80	
		SV202-8		Not Used by HIPAA		
		SV203	R	Line Item Charge Amount	1/18	
		SV204	R	Quantity Qualifier	2/2	DA - Days UN - Unit
		SV205	R	Quantity	1/15	
		SV202-8		Not Used by HIPAA		
		SV207	S	Non-Covered Line Item Amount	1/18	
		SV208-SV210		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
429	2400	PWK01	R	Attachment Report Type Code	2/2	There are 61 possible codes. See HIPAA guide pages 430-431 for the list of codes.
		PWK02	R	Attachment Transmission Code	1/2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only (X12 275) EM - Email FX - By Fax
		PWK03 PWK04		Not Used by HIPAA		
		PWK05		Identification Code Qualifier	1/2	**AC** Attachment Control Number
		PWK06	S	Attachment Control Number	2/80	
		PWK07-PWK09				
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
433	2400	DTP01		Date/Time Qualifier	3/3	**472** Service
		DTP02	R	Service Line From Date	2/3	**D8 or RD8**
		DTP03	S	Service Line To Date	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
435-438	2400	REF01	R	Reference Identification Qualifier	2/3	**6R** Provider Control Number **9B** Repriced Line Item Reference Number **9D** Adjusted Repriced Line Item Reference

						Number
		REF02	R	Reference Identification	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
439-440	2400	AMT01	R	Amount Qualifier Code	1/3	Goods and services tax **=GT** Facility tax **=N8**
		AMT02	R	Monetary Amount	1/18	
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
441	2400	NTE01	S	NTE Ref Code	3/3	TPO - Third Party Organization
		NTE02	S	NTE Note	1/80	Note from Third Party Organization or Repricer
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
442	2400	HCP01	R	Service Line Pricing/Repricing Methodology	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing **10 - Other Pricing** 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	R	Service Line Repricing Allowed Amount	1/18	**REQUIRED to report Service Line Allowed Amount**
		HCP03	S	Service Line Repricing Saving Amount	1/18	
		HCP04	S	Service Line Repricing Organization Identifier	1/50	
		HCP05	S	Service Line Repricing Per Diem or Flat Rate Amount	1/9	
		HCP06	S	Service Line Repricing Approved Ambulatory Patient Group Code	1/50	
		HCP07	S	Service Line Repricing Approved Ambulatory Patient Group Amount	1/18	
		HCP08	S	Service Line Repricing Approved Revenue Code	1/48	
		HCP09	S	Service Line Repricing Approved Procedure Code Qualifier	2/2	HC - CPT/HCPCS code ER - Health Insurance Prospective Payment System HP - HIPPS IV - HIEC WK - DC-10
		HCP10	S	Service Line Repricing Approved Procedure Code	1/48	
		HCP11	S	Service Line Repricing Quantity Qualifier	2/2	DA - Days UN - Unit
		HCP12	S	Service Line Repricing Approved Quantity	1/15	

		HCP13	S	Service Line Reject Reason Code	2/2	T1 - Cannot identify provider as TPO participant T2 - Cannot identify payer as TPO participant T3 - Cannot identify insured as TPO participant T4 - Payer name or identifier missing T5 - Certification information missing T6 - Claim does not contain enough information for repricing
		HCP14	S	Service Line Policy Compliance Code	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital
		HCP15	S	Service Line Exception Code	1/2	1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 - Other
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
449	2410	LIN01		Not Used by HIPAA		
		LIN02			2/2	**N4 National Drug Code in 5-4-2 Format**
		LIN03	R	National Drug Code	1/48	**Required on all physicisan-administered drugs when billed by a provider other than a pharmacy.**
		LIN04-LIN31		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
452	2410	CTP01-CTP03		Not Used by HIPAA		
		CTP04	R	National Drug Unit Count	1/15	**Required on all physicisan-administered drugs when billed by a provider other than a pharmacy.**
		CTP05-1	R	Unit/Basis for Measurement	2/2	Basis of measurement for CTP04 F2 - International Unit GR - Gram ML - Milliliter ME - Milligram UN - Unit
		CTP05-2-CTP05-15		Not Used by HIPAA		
		CTP06-CTP11		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
452	2410	REF01	R	Reference Identification Qualifier	2/3	**XZ Link Sequence Number** **VY Link Sequence Number**
		REF02	R	Link Sequence Number	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
456	2420A	NM101	R	Entity Identifier Code	2/3	**72** Operating Physician
		NM102	R	Entity Type Qualifier	1/1	**1 Person**

		NM103	R	Service Line Operating Provider Last Name	1/60	
		NM104	R	Service Line Operating Provider First Name	1/35	
		NM105	S	Service Line Operating Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Operating Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID NM108=XX
		NM109	S	Service Line Operating Provider Primary ID XX	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
41		REF01	R	Reference Identification Qualifier	1/50	State license number **= 0B** (zero B). Provider UPIN number **= 1G** Provider commercial number **= G2** Location number **= LU**
42		REF02	R	Service Line Operating Provider Secondary ID	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
461	2420B	NM101	R	Entity Identifier Code	2/3	**ZZ** Mutually Defined
		NM102	R	Entity Type Qualifier	1/1	**1 Person**
		NM103	R	Service Line Other Other Operating Provider Last Name	1/60	
		NM104	R	Service Line Other Operating Provider First Name	1/35	
		NM105	S	Service Line Other Operating Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Other Operating Provider Name Suffix	1/10	
		NM109	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX**
		NM109	S	Service Line Other Operating Provider Primary ID	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
464	2420B	REF01	R	Reference Identification Qualifier	2/3	State license number **= 0B** (zero B). Provider UPIN number **= 1G** Provider commercial number **= G2** Location number **= LU**
		REF02	R	Service Line Other Operating Provider Secondary ID	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
466	2420C	NM101	R	Entity Identifier Code	2/3	**82** Rendering Provider
		NM102	R	Entity Type Qualifier	1/1	**1 Person**

		NM103	R	Service Line Rendering Provider Last Name	1/60	
		NM104	R	Service Line Rendering Provider First Name	1/35	
		NM105	S	Service Line Rendering Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Rendering Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX**
		NM109	R	Service Line Rendering Provider Primary ID XX	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
469	2420C	REF01	R	Reference Identification Qualifier	2/3	State license number **= 0B** (zero B Provider UPIN number **= 1G** Provider commercial number **= G2** Location number **= LU**
		REF02	R	Service Line Rendering Provider Secondary ID	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
471	2420D	NM101	R	Entity Identifier Code	2/3	**DN** Referring Provider
		NM102	R	Entity Type Qualifier	1/1	**1 Person**
		NM103	R	Service Line Referring Provider Last Name	1/60	
		NM104	R	Service Line Referring Provider First Name	1/35	
		NM105	S	Service Line Referring Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Referring Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **= XX**
		NM109	R	Service Line Referring Provider Primary ID XX	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
474	2420D	REF01	R	Reference Identification Qualifier	2/3	State license number **= 0B** (zero B). Provider UPIN number **= 1G** Provider commercial number **= G2**
		REF02	R	Service Line Referring Provider Secondary ID 1G	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
476	2430	SVD01	R	Other Payer Primary Identifier	2/80	**Required to report Paid Amount and Patient Responsibility when greater than zero (0)**
		SVD02	R	Service Line Paid Amount	1/18	**NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV203 (Insti) Line Item**

						Charge Amount – Amount must be greater than or equal to zero (0)
		SVD03-1	R	Procedure Code Qualifier	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code HP - Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code IV - HEIC code WK - Advanced Billing (ABC) code
		SVD03-2	R	Procedure Code	1/48	
		SVD03-3	S	Procedure Code Modifier 1	2/2	
		SVD03-4	S	Procedure Code Modifier 2	2/2	
		SVD03-5	S	Procedure Code Modifier 3	2/2	
		SVD03-6	S	Procedure Code Modifier 4	2/2	
		SVD03-7	S	Procedure Code Description	1/80	
		SVD03-8		Not Used by HIPAA		
		SVD04	R	Revenue Code	1/48	
		SVD05	R	Paid Service Unit Count	1/15	
		SVD06	S	Bundled or Unbundled Line Number	1/6	References the service line number which this line was bundled into.
age #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
495	2430	CAS01	R	Service Line Adjustment Group Code 1	1/2	General category of payment adjustment CO – Contractual Obligations CR – Correction and Reversals OA – Other Adjustments PI – Payor Initiated Reductions **PR – Patient Responsibility** **NOTE: Loop 2430 Required to report Patient Responsibility when greater than 0**
		CAS02	R	Adjustment Reason Code 1a	1/5	Service Line adjustment reason code **Member Cost Share (PR qualifier), reason codes:** **1 = Deductible Amount** **2 = Coinsurance Amount** **3 = Co-payment Amount** **Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/**
		CAS03	R	Adjustment Amount 1a	1/18	Montary Amount
		CAS04	S	Adjustment Quantity 1a	1/15	Unit of Service
		CAS05	S	Adjustment Reason Code 1b	1/5	Service Line adjustment reason code
		CAS06	S	Adjustment Amount 1b	1/18	Montary Amount
		CAS07	S	Adjustment Quantity 1b	1/15	Unit of Service
		CAS08	S	Adjustment Reason Code 1c	1/5	1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount
		CAS09	S	Adjustment Amount 1c	1/18	Montary Amount
		CAS10	S	Adjustment Quantity 1c	1/15	Unit of Service
		CAS11	S	Adjustment Reason Code 1d	1/5	Service Line adjustment reason code
		CAS12	S	Adjustment Amount 1d	1/18	Montary Amount
		CAS13	S	Adjustment Quantity 1d	1/15	Unit of Service
		CAS14	S	Adjustment Reason Code 1e	1/5	Service Line adjustment reason code
		CAS15	S	Adjustment Amount 1e	1/18	Montary Amount

		CAS16	S	Adjustment Quantity 1e	1/15	Unit of Service
		CAS17	S	Adjustment Reason Code 1f	1/5	Service Line adjustment reason code
		CAS18	S	Adjustment Amount 1f	1/18	Montary Amount
		CAS19	S	Adjustment Quantity 1f	1/15	Unit of Service
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
486	2430	DTP01	R	Date/Time Qualifier	3/3	**573 Date Claim Paid or Processed** **NOTE: Required when sending Loop 2430**
		DTP02	R	Date Time Period Format Qualifier	2/3	**D8** Date Expressed in Format CCYYMMDD **NOTE: Required when sending Loop 2430**
		DTP03	R	Service Adjudication or Payment Date	1/35	**NOTE: Required when sending Loop 2430**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
487	2430	AMT01		Amount Qualifier Code	1/3	**EAF** Amount Owed
		AMT02	R	Remaining Patient Liability	1/18	
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
488	Transaction Set Trailer	SE01	R	Number of Included Segments	1/10	
		SE02	R	Other Payer ID Referring Provider	4/9	

Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
C.9	Functional Group Trailer	GE01	R	Number of Transactional Sets Included	1/6	
		GE02	R	Group Control Number	1/9	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
C.10	Interchange Control Trailer	IEA01	R	Number of Included Functional Groups	1/5	
		IEA01	R	Interchange Control Number	9/9	

Health Net, LLC

HIPAA Transaction 837 Professional
Standard Companion Guide

Refers to the Implementation Guides Based on X12 version 005010X222A1

Companion Guide Version Number: 2.1

February 22, 2019

Disclosure Statement

This Companion Guide describes the EDI requirements for the submission of CA and Arizona Encounters to Health Net. Throughout the remainder of this document Health Net, LLC will be referred to HNT to describe the all regions of Health Net.

Preface

This Companion Document to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Health Net, LLC Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usage of data expressed in the ASC X12N 837 Implementation Guides.

EDITOR'S NOTE:
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1 Introduction

1.1 Scope

This Companion document supports the implementation of a batch processing application.

HNT will accept inbound submissions that are formatted correctly in X12 requirements. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide.

HNT EDI applications will edit for these conditions and reject files that are out of compliance.

This companion document will specify everything that is necessary to conduct EDI for this standard transaction. This includes;

- Specifications on the communications link
- Specifications on the submission methods
- Specifications on the transactions

1.2 Overview

This companion guide complements the ASC X12N 837 Professional implementation guide currently adopted by HIPAA.

This companion guide will be the vehicle that HNT uses with its trading partners to further qualify the HIPAA adopted implementation guide. This companion guide is compliant with the corresponding HIPAA implementation guide in terms of data element and code sets standards and requirements.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are:

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Trading partner profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

1. Health Care Claim: Professional
   - 837 (005010X222A1)

1.4 Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between trading partners. The computer system generating the transactions must supply complete and accurate information while

the system receiving the transactions must be capable of interpreting and utilizing the information in ASC X12N format, without human intervention.

The transactions must be sent in a specific format that will allow HNT's computer application to translate the data. HNT supports the standard transactions adopted from HIPAA. Maintains a dedicated staff for the purpose of enabling and processing X12 EDI transmissions with its trading partners.

It is the goal of HNT to establish trading partner relationships and to conduct EDI as opposed to paper information flows whenever and wherever possible.

1.5 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.
HIPAA covered healthcare providers that choose to submit transactions electronically, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, the National Provider Identifier (NPI) is meant to be a lasting identifier, and would not change based on changes in a health care provider's name, address, ownership, membership in health plans or Healthcare Provider Taxonomy classification.
HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans (including Health Net), must use only the NPI in the primary identifier position to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

This companion guide has been updated to reflect how the NPI will be integrated in the 837 X12 transaction.

2 Getting Started

2.1 Working with Health Net, LLC

Contact HNT EDI Dept. for all EDI related customer service requests. (Contact information is identified in section 5 below.)

There are three units within HNT that work internally to complete EDI service requests from our trading partners.

The first unit is HNT EDI Operations Dept. This group will serve as the trading partner's central point of contact. This group will also facilitate the implementation of trading partners through all steps of external testing.

The second unit is HNT EDI IT infrastructure group. This is a technical team that implements the communication link and ensures that trading partner to payer connectivity is established properly.

The third unit is HNT EDI IT Translator team. This group is responsible for our inbound and outbound X12 Translator applications.

2.2 Trading Partner Registration

To register as a trading partner with HNT the following sequence of events will take place.

1. Initial conversations are held between the trading partner and HNT
2. Verbal agreements are reached to agree on the transactions that will be conducted.
3. A trading partner agreement and associated companion guides are provided and reviewed.
4. Submitter Id and Receiver Id are established for the purpose of identification.
5. Required trading partner profiling is built into our HNT EDI translator.
6. Test files are exchanged and test runs conducted.
7. Once a brief testing phase is completed and a trading partner agreement is in place; the trading partner is registered.

2.3 Certification and Testing Overview

HNT requires its trading partners to show evidence of third party certification. This is consistent with industry standard conventions that have been adopted for HIPAA Transactions and Code Sets implementation.

HNT will also show evidence of third party certification for standard transactions.

This requirement exists so that the process to test and implement a trading partner for the purpose of conducting EDI with standard transactions is a smooth and efficient process.

The complexity of X12 files when not tested and certified by a third party will cause delays in the ability to enable the X12 submissions in a production environment.

HNT wants to spend the majority of the testing period time, working with prospective trading partners on the agreed components of this companion document rather than X12 or HIPAA implementation guide syntax.

HNT will be certified incorporating the following WEDI/SNIP levels of testing where applicable:
Level 1, Integrity Testing (X12 Syntax)
Level 2, Requirement Testing (HIPAA Implementation Guide Syntax)
Level 3, Balancing Testing (i.e. 835 claim line balancing to the claim document)
Level 4, Situation Testing (Use of Situational Segments that business relevant
Level 5, Code Sets Testing
Level 6, Product Types/Types of Service Testing (i.e. provider specialties)

3 Testing with the Payer

HNT would like to establish with the trading partner a set of scenarios that are intended for testing. This can be a high level description of the contents of the transaction. It should be a representation or cross section of the majority of conditions that will be encountered with production data from these transactions.

HNT requires testing be completed with all trading partners. The testing phase will consist of several smaller phases of testing, as appropriate.

3.1 HIPAA Compliance Testing

HNT uses an industry standard data translator to validate transactions meet the 6 levels of HIPAA compliance, and to translate them into an acceptable format for internal processing. The 997/999 Acknowledgement will be tested during this phase. Any issues identified during this phase of testing will have to be addressed in order for subsequent phases to continue. HNT will use the 277CA for claims acknowledgements.

3.2 Trading Partner Agreement Testing

Trading partner specific setup, as defined in either the trading partner agreement or companion guide will be verified. Generally, this will be done in conjunction with Compliance testing.

3.3 Functional and Regression Testing

Once the transactions have successfully tested through GXS and trading partner specifications, they will be processed through our internal system to ensure they are handled appropriately. Response transactions will be generated during this phase, where applicable.

3.4 Parallel Testing

Depending on the stage of the HNT implementation, a period of parallel testing may be required. This would involve sending the current proprietary transaction format, as well as, sending the same transactions in the x12 format, to our test system. This phase will allow for the comparative analysis necessary to ensure appropriate handling by our system.

4 Connectivity with the Payer / Communications

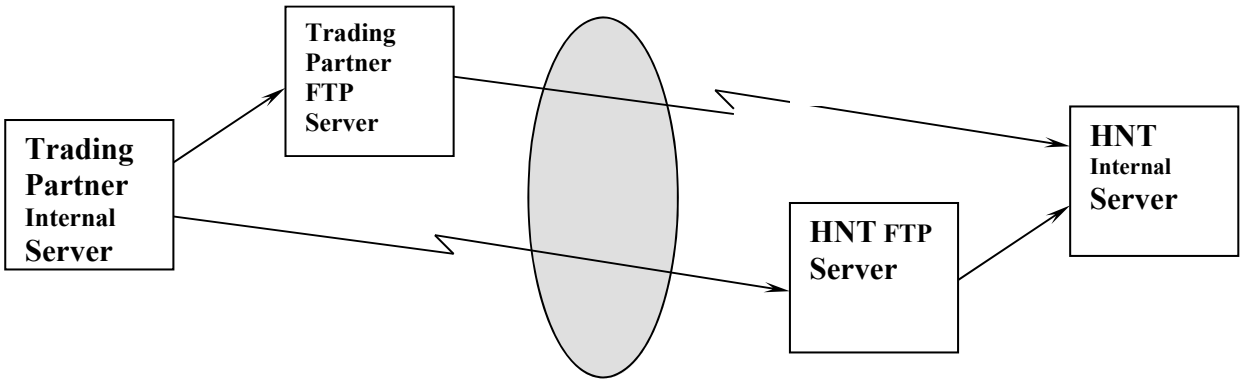
4.1 Process flows

Three file exchange methods are supported to enable batch data file transmission; (1) FTP of encrypted data over the Internet, (2) use of Connect: Direct (NDM) over the AT&T AGNS (formerly Advantis) SNA network, and (3) FTP over frame relay for trading partners with very high volumes.

4.1.1 FTP of Encrypted data over the Internet

One method of exchanging data files is encrypting the file, sending it over the Internet where it is then decrypted. For data inbound to HNT (see Figure 4.1), the trading partner would encrypt the data on an internal server and then transfer to either a trading partner owned FTP server or to HNT FTP server. Then, HNT will retrieve the encrypted file from either the trading partner FTP server or from HNT FTP server to an internal server where the file is decrypted and processed.

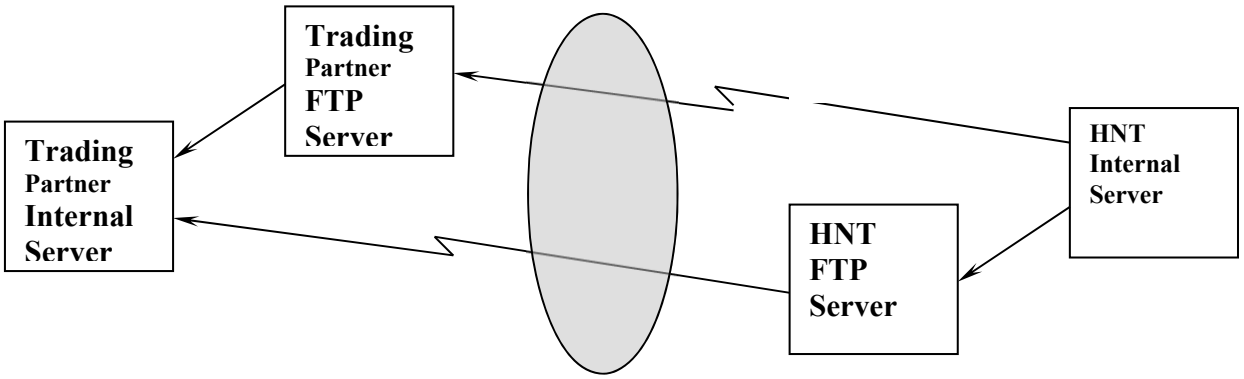
Figure 4.1.1A
FTP of Encrypted Data over the Internet from Trading Partner to HNT



For data outbound from HNT (see Figure 4.1.1B), HNT will generate the X12 data file and encrypt it. Once encrypted, the file will be sent either to HNT's FTP server or the trading partners FTP server. Then the trading partner can retrieve the file from the appropriate FTP server, transfer it to their internal system, encrypt it and process.

Figure 4.1.1B

FTP of Encrypted Data over the Internet from HNT to Trading Partner



4.1.2 Use of Connect: Direct (NDM) over the AT&T AGNS (Advantis) SNA Network

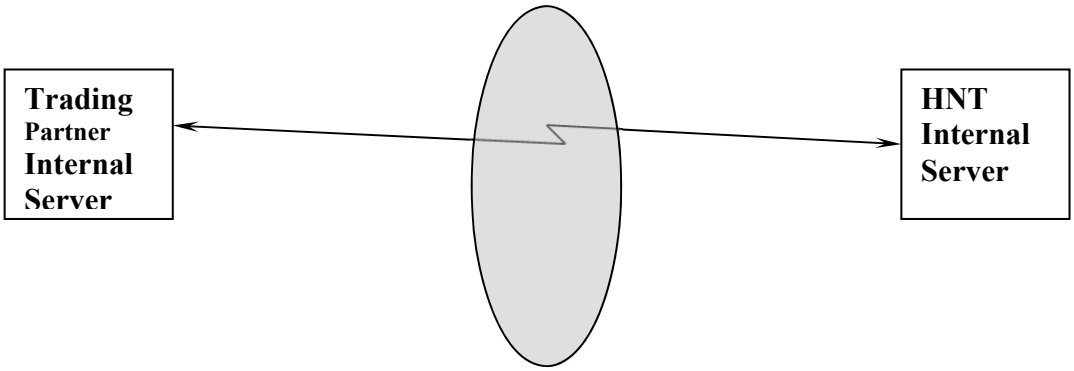
Data may also be exchanged over the AT&T AGNS (formerly Advantis) SNA network (see Figure 4.3). The transmission software must be Sterling

Commerce Connect:Direct (formerly NDM). For data inbound to HNT, the trading partner will make the data file available on their internal server. HNT will retrieve the data from the trading partner server with Connect:Direct (preferred) or the trading partner my initiate the transfer and send the data to HNT's internal server.

Data outbound from HNT takes just the opposite path with either HNT (preferred) or the trading partner initiating the file transfer.

Data transferred over the AGNS network may be encrypted or sent in clear text.

Figure 4.1.2
Connect:Direct Transfer over the AT&T AGNIS Network



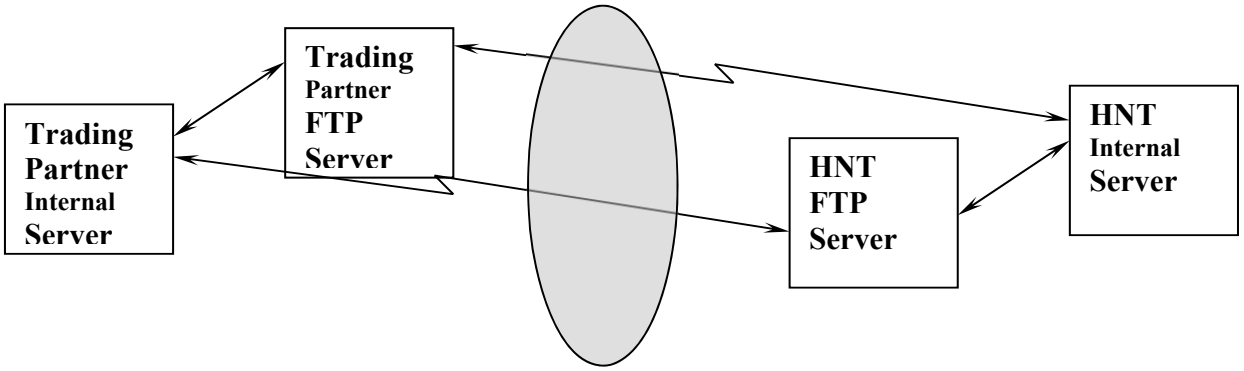
4.1.3 FTP Over Frame Relay

For trading partners with very large data volume to exchange with HNT, a private virtual circuit may be established over a frame relay link (see Figure 4.4). Once established, data will be exchanged similarly to the FTP over the Internet approach except the data will not flow over the Internet.

Data transferred over the frame relay network may be encrypted or sent in clear text.

Figure 4.1.3

FTP Over Frame Relay



4.2 Transmission Administrative Procedures

Before establishing data communications with HNT, a trading partner relationship must exist. As part of the process establishing the relationship, HNT and the trading partner must exchange certain technical information. This information is needed by both parties in order to establish communications.

The information requested will include:

1. Contacts; business, data and communications
2. Dates; testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, userID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be retransmitted, the trading partner will contact their primary contact at HNT. At that time, procedures will be followed for HNT to accept and re-transmit a file.

4.3 Communication protocol specifications

4.3.1 FTP over the Internet

The following items are required to exchange data with HNT utilizing FTP over the Internet. The trading partner is responsible for the acquisition and installation of these items. This list assumes that HNT FTP server will be used.

1. Internet Connectivity; if large files will be exchanged, then the trading partner should consider a broadband connection.
2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include confirming FTP connectivity, exchanging PGP public keys and performing end-to-end communications testing.

Before sending data to HNT, the data must be encrypted with PGP and then sent to the Health Net FTP using the FTP client over the Internet connection. When receiving data from Health Net, the FTP client will be used to get the data from the HNT FTP server after which PGP will be used to decrypt the data.

4.3.2 Connect: Direct over the AT&T AGNS Network

The following items are required to exchange data with HNT utilizing Connect: Direct (formerly NDM) over the AT&T AGNS network (formerly Advantis).

1. SNA Connectivity to the AT&T AGNS network.
2. Connect:Direct software loaded and configured on an applicable host system. HNT runs Connect:Direct on an OpenVMS system. Not all Connect:Direct versions are compatible with Connect:Direct for OpenVMS. The trading partner must confirm that their version is compatible.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Connect:Direct parameters (APPLID, LUs, etc.), submission of security requests to AT&T and end-to-end communications testing.

Using Connect:Direct, data may be “pushed” or “pulled” by either party. HNT prefers to initiate the connection. Data is exchanged when one party initiates a Connect:Direct session with the other and either “pushes” or “pulls” a file to/from the other party.

4.3.3 FTP over Frame Relay

This method of communications is only appropriate for trading partners with a very high and frequent volume. The initial setup of this method can be lengthy.

The following items are required to exchange data with HNT utilizing FTP over Frame Relay.

1. Connectivity to a Frame Relay network common with HNT.

2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Frame Relay PVC parameters and submission of a request to the frame relay carrier for connectivity. Once connectivity is established at the frame relay level, this method is similar to the FTP over the Internet method.

4.4 Passwords

HNT requires the use of UserIDs and Passwords to access its systems and servers. If HNT's FTP server is to be used to exchange data, HNT will assign each trading partner a unique UserID and Password. The UserID and other information will be communicated with the trading partner via e-mail. However, the password will be communicated via another method such as phone or fax.

In the event a trading partner forgets their password, HNT will change the password after verifying the authenticity of the request.

HNT will not utilize a trading partner owned FTP server that is not protected with a UserID and password.

4.5 Encryption

HNT requires the encryption of data that is exchanged via the Internet or any other public network. HNT utilizes PGP with 1024 or 2048 bit keys for file encryption.

5 Contact information

5.1 HNT EDI Department

HNT EDI Dept. is the central point of contact for all trading partner EDI activity including questions relating to file submissions. They will triage the issue and route EDI questions to one of three EDI areas for resolution.

Once resolution is reached, trading partners will receive a response from this same central EDI Dept.

The three areas within HNT EDI that work on EDI customer service issues are;

- HNT IT EDI Translator Team
- HNT IT Payer Connectivity and Infrastructure Team
- HNT EDI Business Operations Team

Contact Phone numbers for our HNT EDI Department:
North East and AZ: 1-866-334-4638
CA and OR: 1-800-977-3568
.

6 Control Segments / Envelopes

6.1 ISA-IEA

See Transaction Specifications, Section 10.

6.2 GS-GE

See Transaction Specifications, Section 10.

6.3 ST-SE

See Transaction Specifications, Section 10.

7 Payer Specific Business Rules and Limitations

- All monetary amounts are to include decimal points with two positions allowed to the right of the decimal point to represent cents.
- CLM segments per patient loop is limited to 100 CLM segments
- Service lines per CLM loop must be limited to 50 service lines
- Billing Provide Name Contact Information (Loop ID 2010AA) is limited to one instance.
- The following segments should **not** be sent:
  - Loop 2010AA REF - Credit/Debit Card Billing Information.
  - Loop 2010BA REF– Property and Casualty Number
  - Loop 2010BD NM1 and REF– Credit/Debit Card Holder Name and Information
  - Loop 2010CA REF– Property and Casualty Claim Number
  - Loop 2300 AMT – Credit/Debit Card Maximum

8 Acknowledgements and or Reports

997/999 and 277CA Acknowledgement will be sent so the trading partner will get confirmation that we received their 837 submission.

9 Trading Partner Agreements

Trading Partner Agreements specify the terms and conditions by which transactions are exchanged electronically with HNT.

This companion document will be an addendum to the trading partner agreement that is signed by both HNT and the trading partner with whom EDI is to be conducted.

Health Net, LLC's trading partner agreement is attached as an appendix to this companion document. The version of X12N that Health Net, LLC is supporting will be identified in the trading partner agreement. As versions offered by HNT change to newer releases of X12N and adopted by HIPAA, the trading partner agreement will be amended to reflect the version changes as they occur and become required.

10 Transaction Specification Information

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
C.3	Interchange Control Header	ISA01	Authorization Information Qualifier	R	2/2	00 – No Authorization Information Present
		ISA02	Authorization Information	R	10/10	Spaces
		ISA03	Security Information Qualifier	R	2/2	00 – No Security Information Present
		ISA04	Security Information	R	10/10	Spaces
		ISA05	Interchange Sender Qualifier	R	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA06	ISA Sender ID	R	15/15	(**As agreed upon**)
		ISA07	Interchange Receiver Qualifier	R	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA08	ISA Receiver ID	R	15/15	HNT Tax ID - 954402957 (**As agreed upon**)
		ISA09	Interchange Date	R	6/6	Date of Transmission (YYMMDD)
		ISA10	Interchange Time	R	4/4	Time of Transmission (HHMM)
		ISA11	Repetition Separator	R	1/1	
		ISA12	Interchange Control Version Number	R	5/5	00501
		ISA13	ISA Control Number	R	9/9	Control number assigned by the sender, Must be identical to control number in IEA02
		ISA14	Acknowledgement Indicator	R	1/1	**1** - Send TA1, **0** - Do not send TA1
		ISA15	Usage Indicator	R	1/1	**T** - Test, **P** - Production
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
C.7	Functional Group Header	GS01	Functional Identifier Code	R	2/2	**HC** - Health Care Claim (837)
		GS02	GS Sender's Code	R	2/15	(**As agreed upon**)
		GS03	GS Receiver's Code	R	2/15	HNCA-ENC (**As agreed upon**)
		GS04	Group GS Date	R	8/8	Functional group creation date (CCYYMMDD)
		GS05	Group GS Time	R	4/8	Functional group creation time (HHMM)
		GS06	Group Control Number	R	1/9	Control number assigned by the sender
		GS07	Responsible Agency Code		1/2	**X** accredited standards committee
		GS08	Version /Release ID Code	R	1/12	005010X222A1
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
70	Transaction Set Header	ST01	Transaction Set Identifier Code	R	3/3	**837** - Health Care Claim: Professional
		ST02	Transaction Set Control Number	R	4/9	Unique control number assigned by sender's translator
		ST03	Transaction Set Version	R	1/35	Matches GS08 value

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
71	Beginning of Hierarchical Transaction	BHT01	Hierarchical Structure Code	R	4/4	**0019** (Information Source, Subscriber, Dependent)
		BHT02	Transaction Set Purpose Code	R	2/2	00 - Original 18 - Reissue
		BHT03	Originator Application Transaction Identifier	R	1/50	
		BHT04	Application Creation Date	R	8/8	CCYYMMDD
		BHT05	Application Creation Time	R	4/8	
		BHT06	Claim or Encounter Indicator	R	2/2	Identifies cap vs. fee for service claims RP - Reporting (**Encounters/ Capitation**)
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
74	1000A	NM101	Entity Identifier Code	R	1/1	**41** (Submitter)
		NM102	Entity Type Qualifier	R	1/60	**1** - person, **2** - Non-Person
		NM103	Submitter Name	R	1/60	
		NM104	Submitter First Name	S	1/35	
		NM105	Submitter Middle Name	S	1/25	
		NM106 NM107	Not Used by HIPAA			
		NM108	Identification Code	R	1/2	46 Electronic Transmitter ID Number ETIN).
		NM109	Submitter Electronic Transmitter ID	R	2/80	9-digit HNT Submitter ID **(Assign by Health Net)**
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
76	1000A	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Submitter Contact Name 1	S	1/60	
		PER04/06/08	Contact Telephone Number 1	R	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 1	R	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 1	R	1/256	**PER03,05,07=FX**
		PER04/06/08	Contact Email Address 1	R	1/256	**PER03,05,07=EM**
		PER09	Not Used by HIPAA			
		PER02	Submitter Contact Name 2	S	1/60	Used if more contact information needed. Inbound: Populated by EDI translator. Outbound: Determined by EDI Business.
		PER04/06/08	Contact Telephone Number 2	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 2	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 2	S	1/256	**PER03,05,07=FX**
		PER04/06/08	Contact Email Address 2	S	1/256	**PER03,05,07=EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

79	1000B	NM101	Entity Identifier Code	R	2/3	**40** (Receiver)
		NM102	Entity Type Qualifier	R	1/1	**2** (Non-Person Entity)
		NM103	Receiver Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**46** Electronic Transmitter ID Number (ETIN)
		NM109	Receiver Electronic Transmitter ID Number	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
83	2000A	PRV01	Provider Code	R	1/3	**BI** (Billing)
		PRV02	Reference Identification Qualifier	R	2/3	**PXC** (Provider Taxonomy Code)
		PRV03	Billing Provider Taxonomy Code	R	1/50	***(REQUIRED)***
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
84	2000A	CUR01	Entity Identifier Code	R	2/3	**85** (Billing Provider)
		CUR02	Currency Code	R	3/3	
		CUR03-CUR16	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
87	2010AA	NM101	Entity Identifier Code	R	2/3	**85** (Billing Provider)
		NM102	Entity Type Qualifier	R	1/1	1=Person 2=Organization
		NM103	Billing Provider Name	R	1/60	
		NM104	Billing Provider First Name	S	1/35	
		NM105	Billing Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Billing Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Billing Provider Primary NPI	R	2/80	**REQUIRED**
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
87	2010AA	N301	Billing Provider Address 1	R	1/55	
		N302	Billing Provider Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
92	2010AA	N401	Billing Provider City	R	2/30	
		N402	Billing Provider State	S	2/2	
		N403	Billing Provider Zip Code	S	3/15	(Nine digit zip code)
		N404	Billing Provider Country Code	S	2/3	Required only if country is not USA.

		N405 N406	Not Used by HIPAA			
		N407	Billing Provider Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
94	2010AA	REF01	Reference Identification Qualifier	**R**	2/3	**EI Employer's identification number (IRS ID number)** SY Social Security Number
		REF02	Billing Provider Taxpayer ID	R	1/50	
		REF02	Billing Provider SSN	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
96	2010AA	REF01	Reference Identification Qualifier	S	2/3	**0B** (State License Number) **1G** (Provider UPIN Number**)**
		REF02	Billing Provider Identification	S	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
98	2010AA	PER01	Contact Function Code	R	2/2	**IC** Billing provider
		PER02	Billing Provider Contact Name 1	S	1/60	
		PER04/06/08	Contact Telephone Number 1	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 1	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 1	S	1/256	**PER03,05,07 = FX**
		PER04/06/08	Contact Email Address 1	S	1/256	**PER03,05,07 = EM**
		PER09	Not Used by HIPAA			
		PER02	Billing Provider Contact Name 2	S	1/60	Used if more Billing Provider contact information needed.
		PER04/06/08	Contact Telephone Number 2	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 2	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 2	S	1/256	**PER03,05,07 = FX**
		PER04/06/08	Contact Email Address 2	S	1/256	**PER03,05,07 = EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes** **S**	**Length**	Notes/ Comments
101	2010AB	NM101	Entity Identifier Code	R	2/3	87 Pay to provider
		NM102	Entity Type Qualifier	R	1/1	1 person 2 non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

116	2000B	SBR01	Payer Responsibility Sequence Number Code	R	1/1	P - Primary S - Secondary T - Tertiary A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility 11 U - Unknown
		SBR02	Individual Relationship Code	S	2/2	Individual Relationship Code "18' - Self, if patient is subscriber. Blank otherwise
		SBR03	Insured Group or Policy Number	S	1/50	
		SBR04	Insured Group Name	S	1/60	
		SBR05	Insurance Type Code	S	1/3	12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 - Medicare Secondary ESRD Beneficiary in 12 month coordination period with employer's group health plan 14 - Medicare Secondary, No-fault Insurance including Auto as Primary 15 - Medicare Secondary Worker's Compensation 16 - Medicare Secondary PHS or Other Federal Agency 41 - Medicare Secondary Black Lung 42 - Medicare Secondary Veteran's Administration 43 - Medicare Secondary Disabled Beneficiary Under Age 65 with LGHP 47 - Medicare Secondary, Other Liability Insurance Primary
		SBR06-SBR08	Not Used by HIPAA			
		SBR09	Claim Filing Indicator Code	S	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity 16 - HMO Medicare Risk 17 - Dental Maintenance Organization AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS CI - Commercial Insurance Company DS - Disability HM - HMO FI - Federal Employees Program LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined

Page	Loop ID	Reference	Name	Codes	Length	Notes/ Comments

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
119	2000B	PAT01-PAT04	Not Used by HIPAA			
		PAT05	Date Time Period Format Qualifier	R	2/3	**D8 - Date** Applies to Subscriber, blank for dependent
		PAT06	Insured Date of Death	R	1/35	
		PAT07	Unit or Basis Measurement Code	R	2/2	**01** (Actual Pounds)
		PAT08	Insured (Patient) Weight	R	1/10	
		PAT09	Pregnancy Indicator	R	1/1	Y - Yes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
121	2010BA	NM101	Entity Identifier Code	R	2/3	**IL** Insured or Subscriber
		NM102	Entity Type Qualifier	R	1/1	1 - person, 2 – Non-Person
		NM103	Subscriber Last Name	R	1/60	
		NM104	Subscriber First Name	S	1/35	
		NM105	Subscriber Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Subscriber Name Suffix	S	1/10	
		NM108	Subscriber Primary ID	S	2/80	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use*)
		NM109	Subscriber Primary ID	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
124	2010BA	N301	Subscriber Address 1	R	1/55	
		N302	Subscriber Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
125	2010BA	N401	Subscriber City Name	R	2/30	
		N402	Subscriber State	S	2/2	
		N403	Subscriber Zip Code	S	3/15	
		N404	Subscriber Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Subscriber Sub-Country Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
127	2010BA	DMG01	Date Time Period Format Qualifier	R	2/3	**D8** Date
		DMG02	Subscriber Birth Date	R	1/35	
		DMG03	Subscriber Gender Code	R	1/1	F - Female M - Male U - Unknown
		DMG04-DMG11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
129	2010BA	REF01	Reference Identification Qualifier	R	2/3	**SY** SSN (cannot be used for Medicare)
		REF02	Subscriber SSN	R	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
130	2010BA	REF01	Reference Identification Qualifier	R	2/3	**Y4** Agency Claim Number
		REF02	Property/Casualty Agency ID number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
131	2010BA	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Property Casualty Patient Contact Name	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number	R	1/256	
		PER05	Communication Number Qualifier	R	2/2	**EX** Telephone Ext.
		PER06	Contact Telephone Extension	S	1/256	
		PER07- PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
133	2010BB	NM101	Entity Identifier Code	R	2/3	**PR** Payer
		NM102	Entity Type Qualifier	R	1/1	**2 –** Non-Person
		NM103	Payer Name	R	1/60	
		NM104- NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	Payer Primary ID XV	S	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
135	2010BB	N301	Payer Address 1	R	1/55	
		N302	Payer Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
136	2010BB	N401	Payer City Name	R	30	
		N402	Payer State	S	2	
		N403	Payer Zip Code	S	3/15	
		N404	Payer Country Code	S	3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Payer Sub-Country Code	S	3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
138	2010BB	REF01	Reference Identification Qualifier	R	2/3	**2U** Supplemental payer id number **FY** Claim office number **EI** Federal Taxpayer's ID Number
		REF02	Payer Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
140	2010BB	REF01	Reference Identification Qualifier	R	2/3	**LU** Provider Location ID Number **G2** Provider Commercial ID Number
		REF02	Billing Provider Secondary ID	R	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
144	2000C	PAT01	Dependent Relationship Code	R	2/2	01 - Spouse 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		PAT02- PAT04	Not Used by HIPAA			
		PAT06	Insured Date of Death	R	1/35	**D8** Date
		PAT08	Insured (Patient) Weight	R	1/10	**01** Actual Pounds
		PAT09	Pregnancy Indicator	R	1/1	Y - Yes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
147	2010CA	NM101	Entity Identification Code	R	2/3	**QC** Patient
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Dependent Last Name	R	1/60	
		NM104	Dependent First Name	R	1/35	
		NM105	Dependent Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Dependent Suffix Name	S	1/10	
		NM108- NM111	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
149	2010CA	N301	Dependent Address 1	R	1/55	
		N302	Dependent Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
150	2010CA	N401	Dependent City Name	R	2/30	
		N402	Dependent State	S	2/2	
		N403	Dependent Zip Code	S	3/15	
		N404	Dependent Country Code	S	2/3	Required only if country not USA.
		N405 N406	Not Used by HIPAA			
		N407	Dependent Sub-Country Code	S	2/3	Required only if country not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
152	2010CA	DMG01	Date Time Period Format Qualifier		2/3	**D8** Date
		DMG02	Dependent Birth Date	R	1/35	
		DMG03	Dependent Gender Code	R	1/1	F - Female M - Male U - Unknown (Note: Required on Outbound)
		DMG04- DMG11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
154	2010CA	REF01	Reference Identification Qualifier	R	2/3	**Y4** Property/Casualty Agency identification number
		REF02	Dependent Secondary ID Y4	R	1/50	
		REF03 REF04	Not Used by HIPAA			

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
155	2010CA	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Property Casualty Patient Contact Name	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number	R	1/256	
		PER05	Communication Number Qualifier	S	2/2	**EX** Telephone Ext.
		PER06	Contact Telephone Extension	S	1/256	
		PER07-PER09	Not Used by HIPAA		1/60	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
157	2300	CLM01	Patient Account Number	R	1/38	
		CLM02	Total Claim Charge Amount	R	1/18	
		CLM03 CLM04	Not Used by HIPAA			
		CLM05-01	Facility Type Code	R	1/2	Place of service
		CLM05-02	Facility Code Qualifier	R	1/1	**B** Claim submission reason code.
		CLM5-03	Claim Frequency Code	R	1/1	1 = Original 7 = Replacement/Adjustment 8 = Void
		CLM06	Provider Signature Indicator	R	1/1	**www.nubc.org** Y - Yes N - No
		CLM07	Provider Accept Assignment Code	S	1/1	A - Assigned B - Assignment Accepted on Clinical Lab Services Only C - Not Assigned
		CLM08	Assignment of Benefits Indicator	R	1/1	Y - Yes N - No W - Not Applicable
		CLM09	Release of Information Indicator	R	1/1	I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim
		CLM10	Patient Signature Source Code	S	1/1	P - Signature generated by provider because patient was unavailable.
		CLM11-1	Related Causes Code 1	R	2/3	AA - Auto Accident EM - Employment OA - Other Accident
		CLM11-2	Related Causes Code 2	S	2/3	AA - Auto Accident EM - Employment OA - Other Accident
		CLM11-3	Not Used by HIPAA			
		CLM11-4	Auto Accident State or Province Code	S	2/2	Auto accident state or province code
		CLM11-5	Auto Accident Country Code	S	2/3	Required only if country is not USA.
		CLM12	Special Program Indicator	S	2/3	02 - Physically Handicapped Children's Program 03 - Special Federal Funding 05 - Disability 7 Third Party Processing Delay 09 - Second Opinion or Surgery
		CLM13-CLM19	Not Used by HIPAA			

		CLM20	Delay Reason Code	S	1/2	1 - Proof of Eligibility Unknown or Unavailable 2 - Litigation, 3 - Authorization Delays 4 - Delay in Certifying Provider, 5 - Delay in Supplying Billing Forms 6 - Delay in Delivery of Custom-made Appliances 7 - Third Party Processing Delay 8 - Delay in Eligibility Determination 9 - Original Claim Rejected or Denied Due to a Reason Unrelated to Billing Limitation Rules 10 - Administration Delay in Prior Approval Process 11 Other 15 Natural Disaster
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
164-181	2300	DTP01	Onset of Current Illness or Injury Date	R	1/35	**431** Onset of Current Symptoms or Illness **454** Initial Treatment **453** Acute Manifestation **439** Accident **484** Last Menstrual Period **471** Hearing or Vision Prescription **297** Last Worked **304** Last Seen **296** Work Return **435 Hospital Admission** **096** Hospital Discharge **090** Assumed Care **091** Relinquished Care **444** Property Casualty First **050** Repricer Received **NOTE: 435 Admission required on Inpatient Claims**
		DTP02	Initial Treatment Date	R	1/35	**D8** - Date (when DTP01 = 314 or 361) or **RD8** - Date Range (when DTP01 = 314)
		DTP03	Last Seen Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
186		CN101	Contract Type Code	R	2/2	01 - Diagnosis Related Group (DRG) 02 - Per Diem 03 - Variable Per Diem 04 - Flat 05 - Capitated 06 - Percent 09 – Other
		CN102	Contract Amount	S	1/18	
		CN103	Contract Percentage	S	1/6	
		CN104	Contract Code	S	1/50	
		CN105	Terms Discount Percentage	S	1/6	
		CN106	Contract Version Identifier	S	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
188	**2300**	**AMT01**	**Amount Qualifier Code**	R	1/3	**F5** Patient Amount Paid/Responsibility
		AMT02	**Patient Amount Paid**	R	1/18	**(REQUIRED)** Monetary Amount – Patient Amount Paid/Responsibility **If Loop 2430 CAS*PR is sent. Value of all CAS*PR must match AMT*F5 Amount**
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

189-206	2300	REF01	Referencing Identification Qualifier	R	2/3	**F5** Medicare Version Code **EW** Mammography Certification **4N** Special Payment Reference **G1 (G - one)** Prior Authorization Number **9F** Referral Number **F8** Original Reference ID Number **X4** CLIA number **9C** Repricer's claim number for a previously adjusted (resubmitted) claim **9A** Repricer's claim number **D9** Clearinghouse or Value Added Network unique claim ID **1J** NPI of Home Health or Hospice Care Facility **EA** Medical Record Identification Number **P4** Project Code **LX** IDE number **NOTE: REF*F8 REQUIRED if CLM05-03 = 7 or 8**
		REF02	Reference Identification Reference Information	R	1/50	**NOTE: If F8 is sent Original Payer Claim Control Number**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
211	2300	CR102	Patient Weight	S	1/10	**LB** Pound **NOTE: Required when CLM05-01 is '41' or '42'**
		CR103	Not Used by HIPAA			
		CR104	Ambulance Transport Reason Code	R	1/1	A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transport E - Patient transferred to rehabilitation facility
		CR106	Transport Distance	R	1/15	**DH** Miles
		CR107 CR108	Not Used by HIPAA			
		CR109	Round Trip Purpose Description	S	1/80	
		CR110	Stretcher Purpose Description	S	1/80	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
214	2300	CR201-CR207	Not Used by HIPAA			
		CR208	Patient Condition Code for Spinal Manipulation	R	1/1	A - Acute Condition C - Chronic Condition D - Non-acute E - Non-Life Threatening F - Routine G - Symptomatic M - Acute Manifestation of a Chronic Condition
		CR209	Not Used by HIPAA			
		CR210	Patient Condition Description - Spinal Manipulation 1	S	1/80	

		CR211	Patient Condition Description - Spinal Manipulation 2	S	1/80	
		CR212	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
216	2300	CRC01	Code Category		2/2	**07** Certification condition code applies indicator. N No, Y Yes
		CRC02	Ambulance Certification Condition Indicator 1	R	1/1	
		CRC03	Ambulance Condition Indicator Code 1a	R	2/3	01 Patient was admitted to a hospital 04 Patient was moved by stretcher 05 Patient was unconscious or in shock 06 Patient was transported in an emergency situation 07 Patient had to be physically restrained 08 Patient had visible hemorrhaging 09 Ambulance service was medically necessary 12 Patient is confined to a bed or chair
		CRC04	Ambulance Condition Indicator Code 1b	S	2/3	See codes in CRC03 (field 48)
		CRC05	Ambulance Condition Indicator Code 1c	S	2/3	See codes in CRC03 (field 48)
		CRC06	Ambulance Condition Indicator Code 1d	S	2/3	See codes in CRC03 (field 48)
		CRC07	Ambulance Condition Indicator Code 1e	S	2/3	See codes in CRC03 (field 48)
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
219	2300	CRC01	Vision Code Category 1	R	2/2	E1 - Spectacle Lenses E2 - Contact Lenses E3 - Spectacle Frames
		CRC02	Vision Certification Condition Indicator 1	R	1/1	Y - Yes N - No
		CRC03	Vision Condition Indicator Code 1a	R	2/3	L1 - General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met L2 - Replacement Due to Loss or Theft L3 - Replacement Due to Breakage or Damage L4 - Replacement Due to Patient Preference L5 - Replacement Due to Medical Reason
		CRC04	Vision Condition Indicator Code 1b	S	2/3	See CRC03 (field 67)
		CRC05	Vision Condition Indicator Code 1c	S	2/3	See CRC03 (field 67)
		CRC06	Vision Condition Indicator Code 1d	S	2/3	See CRC03 (field 67)
		CRC07	Vision Condition Indicator Code 1e	S	2/3	See CRC03 (field 67)
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
221	2300	CRC01	Code Category	R	2/2	**75** Functional limitations
		CRC02	Homebound Certification Condition Indicator	R	1/1	
		CRC03	Homebound Indicator	R	2/3	IH - Independent at Home
		CRC04-CRC07	Not Used by HIPAA		1/1	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
221	2300	CRC01	Code Category		2/2	**ZZ** Mutually defined

		CRC02	EPSDT Certification Condition Indicator	R	1/1	Y - Yes N - No
		CRC03	EPSDT Condition Indicator Code 1	R	2/3	AV - Available - Not Used NU - Not Used S2 - Under Treatment ST - New Services Requested
		CRC04	EPSDT Condition Indicator Code 2	S	2/3	See CRC03 (field 89)
		CRC05	EPSDT Condition Indicator Code 3	S	2/3	See CRC03 (field 89)
		CRC06 CRC07	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
226	2300	HI01-1	Principal Diagnosis Qualifier	R	1/3	BK - ICD-9 ABK - ICD-10
		HI01-2	Principal Diagnosis	R	1/30	
		HI02-1	Diagnosis Qualifier 2	R	1/3	BK - ICD-9 ABK - ICD-10
		HI02-2	Diagnosis Code 2	S	1/30	
		HI03-1	Diagnosis Qualifier 3	R	1/3	BK - ICD-9 ABK - ICD-10
		HI03-2	Diagnosis Code 3	S	1/30	
		HI04-1	Diagnosis Qualifier 4	R	1/3	BK - ICD-9 ABK - ICD-10
		HI04-2	Diagnosis Code 4	S	1/30	
		HI05-1	Diagnosis Qualifier 5	R	1/3	BK - ICD-9 ABK - ICD-10
		HI05-2	Diagnosis Code 5	S	1/30	
		HI06-1	Diagnosis Qualifier 6	R	1/3	BK - ICD-9 ABK - ICD-10
		HI06-2	Diagnosis Code 6	S	1/30	
		HI07-1	Diagnosis Qualifier 7	R	1/3	BK - ICD-9 ABK - ICD-10
		HI07-2	Diagnosis Code 7	S	1/30	
		HI08-1	Diagnosis Qualifier 8	R	1/3	BK - ICD-9 ABK - ICD-10
		HI08-2	Diagnosis Code 8	S	1/30	
		HI09-1	Diagnosis Qualifier 9	R	1/3	BK - ICD-9 ABK - ICD-10
		HI09-2	Diagnosis Code 9	S	1/30	
		HI010-1	Diagnosis Qualifier 10	R	1/3	BK - ICD-9 ABK - ICD-10
		HI10-2	Diagnosis Code 10	S	1/30	
		HI011-1	Diagnosis Qualifier 11	R	1/3	BK - ICD-9 ABK - ICD-10
		HI11-2	Diagnosis Code 11	S	1/30	
		HI012-1	Diagnosis Qualifier 12	R	1/3	BK - ICD-9 ABK - ICD-10
		HI12-2	Diagnosis Code 12	S	1/30	
			Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
239	2300	HI01-2	Principal Anesthesia Related Code	S	1/30	**BP** Health Care Financing Administration Common Procedural Coding System Principal Procedure
		HI02-2	Additional Anesthesia Related Code	S	1/30	**BO** Health Care Financing Administration Common Procedural Coding System
		HI03-HI12	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
242	2300	HI01-2	Condition Indicator Code 1	S	1/30	**BG** Condition
		HI02-2	Condition Indicator Code 2	S	1/30	See HI01-2 for codes
		HI03-2	Condition Indicator Code 3	S	1/30	See HI01-2 for codes
		HI04-2	Condition Indicator Code 4	S	1/30	See HI01-2 for codes

		HI05-2	Condition Indicator Code 5	S	1/30	See HI01-2 for codes
		HI06-2	Condition Indicator Code 6	S	1/30	See HI01-2 for codes
		HI07-2	Condition Indicator Code 7	S	1/30	See HI01-2 for codes
		HI08-2	Condition Indicator Code 8	S	1/30	See HI01-2 for codes
		HI09-2	Condition Indicator Code 9	S	1/30	See HI01-2 for codes
		HI10-2	Condition Indicator Code 10	S	1/30	See HI01-2 for codes
		HI11-2	Condition Indicator Code 11	S	1/30	See HI01-2 for codes
		HI12-2	Condition Indicator Code 12	S	1/30	See HI01-2 for codes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
252	2300	HCP01	Claim Pricing/Repricing Methodology	R	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at a Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing 10 - Other Pricing 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	Claim Repricing Allowed Amount	R	1/18	
		HCP03	Claim Repricing Saving Amount	S	1/18	
		HCP04	Claim Level Repricing Organization ID	S	1/50	
		HCP05	Claim Repricing Per Diem or Flat Rate	S	1/9	
		HCP06	Claim Repricing Approved Ambulatory Patient Group Code	S	1/50	
		HCP07	Claim Repricing Approved Ambulatory Patient Group Amount	S	1/18	
		HCP08-HCP12	Not Used by HIPAA			
		HCP13	Claim Repricing Reject Reason Code	S	2/2	T1 - Cannot Identify Provider as TPO (3rd Party Organization) Participant T2 - Cannot Identify Payer as TPO Participant T3 - Cannot Identify Insured as TPO Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing T6 - Claim does not contain enough information for repricing
		HCP14	Claim Repricing Policy Compliance Code	S	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance) 3 - Not Medically Necessary (Non-Compliance) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital
		HCP15	Claim Repricing Exception Code	R	1/2	1 - Non-Network professional provider in Network hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 – Other **NOTE: REQUIRED if Known** **1 or 3 = Out of Network** **6 = In Network**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
257	2310A	NM101	Entity Identifier Code	R	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Referring Provider Last Name	R	1/60	
		NM104	Referring Provider First Name	S	1/35	
		NM105	Referring Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Referring Provider Name Suffix	S	1/10	
		NM109	Referring Provider Primary ID XX	R	2/80	**XX** NPI (HIPAA National Provider ID)
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
257	2310A	NM101	Entity Identifier Code	R	2/3	**P3** Primary Care Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	PCP Provider Last Name	R	1/60	
		NM104	PCP Provider First Name	S	1/35	
		NM105	PCP Provider Middle Name	S	1/25	
		NM107	PCP Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** NPI (HIPAA National Provider ID)
		NM109	PCP Provider Primary ID	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
260	2310A	REF01	Reference Identifier Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number (**REQUIRED**) **1G** Provider UPIN number
		REF02	Referring Provider Secondary ID	S	1/50	**REF*G2*9999 = Tribal Provider**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments** In the absence of a valid Rendering Provider Name or NPI (i.e. PA, PT, or nurse) please use the Physician Name and NPI that the services were provided under or the Physician Name and NPI that the member is assigned to.
262	**2310B**	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider **REQUIRED *if different than Billling***
		NM102	**Entity Type Qualifier**	**R**	**1/1**	**1 Person**
		NM103	**Rendering Provider Last/Organization Name**	**R**	**1/60**	
		NM104	Rendering Provider First Name	S	1/35	
		NM105	Rendering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Rendering Provider Name Suffix	S	1/10	
		NM108	**Identification Code Qualifier**	**R**	**1/2**	**XX** NPI (HIPAA National Provider ID)
		NM109	**Rendering Provider Primary ID**	**R**	**2/80**	**REQUIRED *if different than Billling***

		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
265	2310B	PRV01	Provider Code		1/3	**PE** Performing
		PRV02	Reference Identifier Qualifier		2/3	**PXC** Rendering provider specialty type
		PRV03	**Rendering Provider Taxonomy Code**	R	1/50	***REQUIRED if Rendering Provider is present***
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
267	2310B	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Rendering Provider Secondary ID G2	S	1/50	**REF*G2*9999 = Tribal Provider**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
269	2310C	NM101	Entity Identifier Code	R	2/3	**77** Service Location **NOTE: Required if Rendering Provider is present**
		NM102	Entity Type Qualifier	R	1/1	**2** (non-Person)
		NM103	Service Facility Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Facility Primary ID	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
272	2310C	N301	Service Facility Address 1	R	1/55	
		N302	Service Facility Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
273	2310C	N401	Service Facility City	R	2/30	
		N402	Service Facility State	S	2/2	
		N403	Service Facility Zip Code	S	3/15	
		N404	Service Facility Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Service Facility Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
275	2310C	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Service Facility Secondary ID	S	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
277	2310C	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Service Facility Contact Name 1	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number 1	S	1/256	
		PER05	Communication Number Qualifier	S	2/2	**EX** Telephone Ext
		PER06	Contact Telephone Extension 1	S	1/256	
		PER07- PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
280	2310D	NM101	Entity Identifier Code	R	2/3	**DQ** Referring Provider Entity Identifier Code
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Supervising Provider Last Name	R	1/60	
		NM104	Supervising Provider First Name	S	1/35	
		NM105	Supervising Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Supervising Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** NPI (HIPAA National Provider ID)
		NM109	Supervising Provider Primary ID XX	R	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
283	2310D	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Supervising Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
285	2310E	NM101	Entity Identifier Code	R	2/3	**PW** Pickup address
		NM102	Entity Type Qualifier	R	1/1	**Note: Required when CLM05-01 = '41'** **2** non-person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
287	2310E	N301	Ambulance Pickup Address 1	R	1/55	
		N302	Ambulance Pickup Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
288	2310E	N401	Ambulance Pickup City	R	2/30	
		N402	Ambulance Pickup State	R	2/2	
		N403	Ambulance Pickup Zip Code	R	3/15	
		N404	Ambulance Pickup Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Pickup Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

	2310F	NM101	Entity Identifier Code	R	2/3	**45** drop off location **Note: Required when CLM05-01 = '41'**
		NM102	Entity Type Qualifier	R	1/1	**2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
292	2310F	N301	Ambulance Drop-Off Address 1	R	1/55	
		N302	Ambulance Drop-Off Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
293	2310F	N401	Ambulance Drop-Off City	R	2/30	
		N402	Ambulance Drop-Off State	R	2/2	
		N403	Ambulance Drop-Off Zip Code	R	3/15	
		N404	Ambulance Drop-Off Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Drop-Off Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
295	2320	SBR01	Payer Responsibility Sequence Number Code	R	1/1	A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven **P - Primary** S - Secondary T - Tertiary U - Unknown **NOTE: Required to report Paid Amount and non-zero Member Cost Share in Loop 2430**
		SBR02	Individual Relationship Code	R	2/2	01 - Spouse 18 - Self 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		SBR03	Other Insured Group or Policy Number	S	1/50	
		SBR04	Other Insured Group Name	S	1/60	

		SBR05	Insurance Type Code	S	1/3	12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 - Medicare Secondary End-Stage Renal Disease Beneficiary in 12 month coordination period with employer's group health plan 14 - Medicare Secondary, No-fault Insurance including Auto as Primary 15 - Medicare Secondary Worker's Compensation 16 - Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 - Medicare Secondary Black Lung 42 - Medicare Secondary Veteran's Administration 43 - Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 - Medicare Secondary, Other Liability Insurance is Primary
		SBR06 SBR08	Not Used by HIPAA			
		SBR09	Claim Filing Indicator Code	S	1/2	11' - Other Non-Federal Programs, '12' - PPO, '13' - POS, '14' - EPO, '15' - Indemnity, '16' - HMO Medicare Risk, '17' - Dental Maintenance Organization 'AM' - Automobile Medical, 'BL' - Blue Cross/Blue Shield, 'CH' - CHAMPUS, 'CI' - Commercial Insurance Company, 'DS' - Disability, 'HM' - HMO, 'FI' - Federal Employees Program, 'LM' - Liability Medical, 'MA' - Medicare Part A, 'MB' - Medicare Part B, 'MC' - Medicaid, 'OF' - Other Federal Program, 'TV' - Title V, 'VA' - Veteran Administration Plan, 'WC' - Workers' Compensation Health Claim, 'ZZ' - Mutually Defined
Seg:	**CAS**	**Occur 5**	**Claim Level Adjustments**	**S**	**Page: 299**	
299-304	2320	CAS01	Claim Adjustment Group Code 1	R	1/2	General category of payment adjustment CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** **NOTE: Required at Loop 2430**
		CAS02	Adjustment Reason Code 1a	R	1/5	
		CAS03	Adjustment Amount 1a	R	1/18	
		CAS04	Adjustment Quantity 1a	S	1/15	
		CAS05	Adjustment Reason Code 1b	S	1/5	
		CAS06	Adjustment Amount 1b	S	1/18	
		CAS07	Adjustment Quantity 1b	S	1/15	
		CAS08	Adjustment Reason Code 1c	S	1/5	
		CAS09	Adjustment Amount 1c	S	1/18	
		CAS10	Adjustment Quantity 1c	S	1/15	
		CAS11	Adjustment Reason Code 1d	S	1/5	
		CAS12	Adjustment Amount 1d	S	1/18	
		CAS13	Adjustment Quantity 1d	S	1/15	
		CAS14	Adjustment Reason Code 1e	S	1/5	
		CAS15	Adjustment Amount 1e	S	1/18	
		CAS16	Adjustment Quantity 1e	S	1/15	

		CAS17	Adjustment Reason Code 1f	S	1/5	
		CAS18	Adjustment Amount 1f	S	1/18	
		CAS19	Adjustment Quantity 1f	S	1/15	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
305-307	2320	AMT01	Amount Qualifier Code	R	1/3	**D** Payor Amount Paid **(Required when sending SVD segment)** **EAF** Amount Owed **A8** Non-covered Charges - Actual
		AMT02	Amount	R	1/18	
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
308	2320	OI01 OI02	Not Used by HIPAA			
		OI03	Benefits Assignment Certification Indicator	R	1/1	Indicates whether insured has authorized benefits to be assigned to the provider N - No W - Not Applicable (Use when patient refuses to assign benefits) Y – Yes **(Required when sending segment)**
		OI04	Patient Signature Source Code	R	1/1	P - Signature generated by provider
		OI05	Not Used by HIPAA			
		OI06	Release of Information Code	R	1/1	Indicates whether provider has signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has signed statement perm
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
310	2320	MOA01	Reimbursement Rate	S	1/10	
		MOA02	Claim HCPCS Payable Amount	S	1/18	
		MOA03	Remittance Remark Code 1	S	1/50	
		MOA04	Remittance Remark Code 2	S	1/50	
		MOA05	Remittance Remark Code 3	S	1/50	
		MOA06	Remittance Remark Code 4	S	1/50	
		MOA07	Remittance Remark Code 5	S	1/50	
		MOA08	Claim ESRD Payment Amount	S	1/18	End Stage Renal Disease payment amount
		MOA09	Nonpayable Professional Component Amount	S	1/18	Professional component amount billed but not payable
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
313	2330A	NM101	Entity Identifier Code	R	2/3	**IL** Insured or Subscriber **(Required when sending SVD segment)**
		NM102	Entity Type Qualifier	R	1/1	**1** - person **2** - organization
		NM103	Other Insured Last Name	R	1/60	
		NM104	Other Insured First Name	S	1/35	
		NM105	Other Insured Middle Name	S	1/25	
		NM106	Not Used by HIPAA			

		NM107	Other Insured Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use)*
		NM109	Other Insured Primary ID	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
316	2330A	N301	Other Insured Address 1	R	1/55	
		N302	Other Insured Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
317	2330A	N401	Other Insured City	R	2/30	**(Required when sending SVD segment**
		N402	Other Insured State	S	2/2	
		N403	Other Insured Zip Code	S	3/15	
		N404	Other Insured Country Code	S	2/3	
		N405 N406	Not Used by HIPAA			
		N407	Other Insured Sub-Country Code	S	2/3	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
319	2330A	REF01	Reference Identification Qualifier		2/3	**SY** Social security number (cannot be used for Medicare)
		REF02	Other Insured Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
320	2330B	NM101	Entity Identifier Code	R	2/3	**PR** Payer **(Required when sending SVD segment)**
		NM102	Entity Type Qualifier	R	1/1	**2** Non-Person Entity
		NM103	Other Payer Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	½	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	Other Payer Primary ID 2	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
322	2330B	N301	Other Payer Address 1	R	1/55	
		N302	Other Payer Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
323	2330B	N401	Other Payer City	R	2/30	
		N402	Other Payer State	S	2/2	
		N403	Other Payer Zip Code	S	3/15	
		N404	Other Payer Country Code	S	2/3	
		N405 N406	Not Used by HIPAA			
		N407	Other Payer Sub-Country Code	S	2/3	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

325	2330B	DTP01	Date/Time Qualifier	R	3/3	**573** Date Claim paid
		DTP02	Date Time Period Format Qualifier	R	2/3	**D8** Date Expressed in Format CCYYMMDD
		DTP03	Other Payer Adjudication or Payment Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
326	2330B	REF01	Reference Identification Qualifier	R	2/3	**2U** Payer identification number **FY** Claim office number **EI** Tax ID
		REF02	Other Payer Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
328	2330B	REF01	Reference Identification Qualifier	R	2/3	**G1** Prior Authorization Number **9F** Referral number **T4** Adjustment Indicator **F8** Original reference number
		REF02	Other Payer Control ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
332	2330C	NM101	Entity Identifier Code	R	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
334	2330C	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number
		REF02	Other Payer Referring Provider 1 Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
336	2330D	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider
		NM102	Entity Type Qualifier	R	1/1	**1** person **2** non-person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
338	2330D	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number
		REF02	Other Payer Rendering Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
340	2330E	NM101	Entity Identifier Code	R	2/3	**77** Service Location
		NM102	Entity Type Qualifier	R	1/1	**1** Person

		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
342	2330E	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Service Facility Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
340	2330F	NM101	Entity Identifier Code	R	2/3	**DQ** Supervising Physician
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
345	2330F	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Supervising Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
347	2330G	NM101	Entity Identifier	R	2/3	**85** Billing Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person **2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
349	2330G	REF01	Reference Identification Qualifier	R	2/3	**LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Billing Provider Secondary ID	R	1/50	**LU** Location Number
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
350	2400	LX01	Service Line Number	R	1/6	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
351	2400	SV101-1	Procedure Code Qualifier	R	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing (ABC) code
		SV101-2	Procedure Code	R	1/48	
		SV101-3	Procedure Code Modifier 1	S	2/2	**NOTE: 340B physician administered drug include modifier "UD' in either SV101-3, -4, -5, or -6**
		SV101-4	Procedure Code Modifier 2	S	2/2	
		SV101-5	Procedure Code Modifier 3	S	2/2	
		SV101-6	Procedure Code Modifier 4	S	2/2	
		SV101-7	Procedure Code Description	S	1/80	Additional information when procedure code does not definitively describe condition.
		SV101-8	Not Used by HIPAA			

		SV102	Line Item Charge Amount	R	1/18	Submitted charge amount (implied decimal) Note: Zero is acceptable
		SV103	Quantity Qualifier	R	2/2	MJ - Minutes UN - Unit
		SV104	Quantity	R	1/15	Number of units (floating point)
		SV105	Place of Service Code	S	1/2	
		SV106	Not Used by HIPAA			
		SV107-1	Diagnosis Code Pointer 1	R	1/2	Diagnosis code pointer
		SV107-2	Diagnosis Code Pointer 2	S	1/2	Additional diagnosis code pointer
		SV107-3	Diagnosis Code Pointer 3	S	1/2	Additional diagnosis code pointer
		SV107-4	Diagnosis Code Pointer 4	S	1/2	Additional diagnosis code pointer
		SV108	Not Used by HIPAA			
		SV109	Emergency Indicator	S	1/1	Y - Yes
		SV110	Not Used by HIPAA			
		SV111	EPSDT Indicator	S	1/1	Y - Yes
		SV112	Family Planning Indicator	S	1/1	Y - Yes
		SV113	Not Used by HIPAA			
		SV114	Not Used by HIPAA			
		SV115	Co-Pay Status Code	S	1/1	0 - Copay Exempt
		SV116-SV121	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
359	2400	SV501-1	Product/Service ID Qualifier		2/2	**HC** (HCPCS) Codes
		SV501-2	Durable Medical Equipment Procedure Code	R	1/48	
		SV501-3-SV501-8	Not Used by HIPAA			
		SV503	Length of Medical Necessity	R	1/15	**DA** Length of medical necessity in days (floating point)
		SV504	DME Rental Price	R	1/18	DME Rental Price (implied decimal)
		SV505	DME Purchase Price	R	1/18	DME Purchase Price (implied decimal)
		SV506	Rental Unit Price Indicator	R	1/1	1 - Weekly 4 - Monthly 6 - Daily
		SV507	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
362	2400	PWK01	Attachment Report Type Code	R	2/2	03 Report Justifying Treatment Beyond Utilization Guidelines 04 Drugs Administered 05 Treatment Diagnosis 06 Initial Assessment 07 Functional Goals 08 Plan of Treatment 09 Progress Report 10 Continued Treatment 11 Chemical Analysis 13 Certified Test Report 15 Justification for Admission 21 Recovery Plan A3 Allergies/Sensitivities Document A4 Autopsy Report AM Ambulance Certification AS Admission Summary B2 Prescription B3 Physician Order B4 Referral Form BR Benchmark Testing Results

						BS Baseline BT Blanket Test Results CB Chiropractic Justification CK Consent Form(s) CT Certification D2 Drug Profile Document DA Dental Models DB Durable Medical Equipment Prescription DG Diagnostic Report DJ Discharge Monitoring Report DS Discharge Summary EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) HC Health Certificate HR Health Clinic Records I5 Immunization Record IR State School Immunization Records LA Laboratory Results M1 Medical Record Attachment MT Models NN Nursing Notes OB Operative Note OC Oxygen Content Averaging Report OD Orders and Treatments Document OE Objective Physical Examination (including vital signs) Document OX Oxygen Therapy Certification OZ Support Data for Claim P4 Pathology Report P5 Patient Medical History Document PE Parenteral or Enteral Certification PN Physical Therapy Notes PO Prosthetics or Orthotic Certification PQ Paramedical Results PY Physician's Report PZ Physical Therapy Certification RB Radiology Films RR Radiology Reports RT Report of Tests and Analysis Report RX Renewable Oxygen Content Averaging Report SG Symptoms Document V5 Death Notification XP Photographs
3	PWK02	1/2	Attachment Transmission Code	R	2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only EM - Email FX - By Fax FT - File Transfer
	PWK03 PWK04		Not Used by HIPAA			
	PWK05					**AC** Attachment Control Number
4	PWK06	2/80	Attachment Control Number	S	80	
	PWK07- PWK09					

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
366	2400	PWK01	Report Type Code		2/2	
		PWK02	DMERC Attachment Transmission Code	R	1/2	AB - Previously Submitted to Payer AD - Certification Included in this Claim AF - Narrative Segment Included in this Claim AG - No Documentation is Required NS - Not Specified (Paperwork available on request at provider's site)

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
368	2400	CR101	Unit or Basis for Measurement Code		2/2	**LB** Pound
		CR102	Patient Weight	S	1/10	
		CR103				Not Used by HIPAA
		CR104	Ambulance Transport Reason Code	R	1/1	A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transport E - Patient transported to Rehabilitation Facility
		CR105	Unit or Basis for Measurement Code		2/2	**DH** Miles
		CR106	Transport Distance	R	1/15	
		CR107 CR108	Not Used by HIPAA			
		CR109	Round Trip Purpose Description	S	1/80	
		CR110	Stretcher Purpose Description	S	1/80	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
371	2400	CR301	DME Certification	S	1/1	I - Initial R - Renewal S - Revised
		CR302	Unit or Basis for Measurement Code			**MO** Months
		CR303	DME Duration	S	1/15	
		CR304 CR305	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
373	2400	CRC01	Code Category		2/2	**07** Ambulance Certification
		CRC02	Ambulance Certification Condition 1	S	1/1	Y - Yes N - No . Note: This segment can occur up to 3 times. 1st occurrence
		CRC03	Ambulance Condition Indicator 1	S	2/3	01 - Patient was admitted to a hospital 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service medically necessary 12 - Patient is confined to a bed or chair
		CRC04	Ambulance Condition Indicator 2	S	2/3	See CRC03 for list.
		CRC05	Ambulance Condition Indicator 3	S	2/3	See CRC03 for list.
		CRC06	Ambulance Condition Indicator 4	S	2/3	See CRC03 for list.
		CRC07	Ambulance Condition Indicator 5	S	2/3	See CRC03 for list.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
376	2400	CRC01	Code Category		2/2	**70** Hospice
		CRC02	Hospice Employee Indicator	S	1/1	Y - Yes N - No
		CRC03				**65** Open
		CRC04- CRC07	Not Used by HIPAA			

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
378	2400	CRC01	Code Category		2/2	**09 D**urable Medical Equipment Certification
		CRC02	DME Certification Condition	S	1/1	Y - Yes N - No
		CRC03	DME Certification Condition Indicator 1	S	2/3	38 - Certification signed by the physician is on file at the supplier's office ZV - Replacement Item
		CRC04	DME Certification Condition Indicator 2	S	2/3	38 - Certification signed by the physician is on file at the supplier's office ZV - Replacement Item
		CRC05-CRC07	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
380	2400	DTP01	Date/Time Qualifier	R	3/3	**472** Service
		DTP02	Date Time Period Format Qualifier		2/3	**D8 or RD8**
		DTP03	Service Line To Date	S	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
386	2400	DTP03	Prescription Date	R	1/35	**DTP01 = 471** Prescription **DTP02 = D8**
		DTP03	Certification Revision Date	R	1/35	**DTP01 = 607** Certification Revision **DTP02 = D8**
		DTP03	Begin Therapy Date	R	1/35	**DTP01 = 463** Begin Therapy **DTP02 = D8**
		DTP03	Last Certification Date	R	1/35	**DTP01 = 461**Last Certification **DTP02 = D8**
		DTP03	Date Last Seen	R	1/35	**DTP01 = 304** Last Seen **DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
387	2400	DTP03	Most Recent Hemoglobin or Hematocrit Date	R	1/35	Test Date. **DTP01 = 738 DTP02 = D8**
		DTP03	Most Recent Serum Creatine Date	R	1/35	Test Date. **DTP01 = 739 DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
390	2400	DTP03	Shipped Date	R	1/35	**DTP01 = 011** Shipped **DTP02 = D8**
		DTP03	Last X-Ray Date	R	1/35	**DTP01 = 455** Last X-Ray **DTP02 = D8**
		DTP03	Initial Treatment Date	R	1/35	**DTP01 = 454** Initial Treatment **DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
391-392	2400	QTY01	Quantity Qualifier		2/2	
		QTY02	Ambulance Patient Count	R	1/15	**PT** Patients
		QTY02	Obstetric Anesthesia Additional Units	R	1/15	**FL** Units
		QTY03 QTY04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
393	2400	MEA01	Test Result ID 1	R	2/2	OG - Original TR - Test Results
		MEA02	Test Result Qualifier 1	R	1/3	HT – Height R1 – Hemoglobin R2 – Hematocrit R3 - Epoetin Starting Dosage R4 - Creatinine
		MEA03	Test Result Value 1	R	1/20	
		MEA01	Test Result ID 2	R	2/2	2nd occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 2	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 2	R	1/20	
		MEA01	Test Result ID 3	R	2/2	3rd occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 3	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 3	R	1/20	

		MEA01	Test Result ID 4	R	2/2	4th occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 4	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 4	R	1/20	
		MEA01	Test Result ID 5	R	2/2	5th occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 5	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 5	R	1/20	
		MEA04-MEA12	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
395	2400	CN101	Contract Type Code	R	1/2	01 - Diagnosis Related Group (DRG) 02 - Per Diem 03 - Variable Per Diem 04 – Flat 05 – Capitated 06 – Percent 09 - Other
		CN102	Contract Amount	S	1/18	
		CN103	Contract Percentage	S	1/6	
		CN104	Contract Code	S	1/50	
		CN105	Terms Discount Percentage	S	1/6	
		CN106	Contract Version Number	S	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
397-398	2400	REF01	Reference Identification Qualifier	R	2/3	**9B** Repriced Line Item Reference Number **9D** Adjusted Repriced Line Item Reference Number
		REF02	Reference Identification	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
399	2400	REF01	Reference Identification Qualifier	R	2/3	**G1** Prior Authorization Number
		REF02	Prior Authorization Number 2	R	1/50	See first REF02 above for codes/notes.
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
401-406	2400	REF01	Reference Identification Qualifier	R	2/3	**6R** Provider Control Number **BT** Batch Number **EW** Mammography Certification Number **X4** CLIA Number **F4** CLIA Facility Certification Number
		REF02	Line Item Control Number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
407	2400	REF01		R	2/3	**9F** Referral Number
		REF02	Referral Number	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
409-410	2400	AMT01	Amount Qualifier Code	R	1/3	**T** Tax **F4** Postage Claimed
		AMT02	Postage Claimed Amount	R	1/18	
		AMT03	Not Used by HIPAA			
Page	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
415	2400	PS101	Purchased Service Provider Identifier	R	1/50	
		PS102	Purchased Service Charge Amount	R	1/18	
		PS103	Not Used by HIPAA			
416	2400	HCP01	Line Pricing/Repricing Methodology	R	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at a Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing **10 - Other Pricing** 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	**Line Repricing Allowed Amount**	R	1/18	**REQUIRED to report Service Line Allowed Amt**
		HCP03	Line Repricing Saving Amount	S	1/18	
		HCP04	Line Level Repricing Organization ID	S	1/50	
		HCP05	Line Repricing Per Diem or Flat Rate	S	1/9	
		HCP06	Line Repricing Approved Ambulatory Patient Group Code	S	1/50	
		HCP07	Line Repricing Approved Ambulatory Patient Group Amount	S	1/18	
		HCP08	Not Used by HIPAA			
		HCP09	Line Repricing Procedure Code Qualifier	S	2/2	ER - Jurisdiction Specific Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing Concepts (ABC) Codes
		HCP10	Line Repricing Procedure Code	S	1/48	
		HCP11	Line Repricing Procedure Quantity Qualifier	S	2/2	MJ - Minutes UN - Unit
		HCP12	Line Repricing Procedure Quantity	S	1/15	
		HCP13	Line Repricing Reject Reason Code	S	2/2	T1 - Cannot Identify Provider as TPO (Third Party Organization) Participant T2 - Cannot Identify Payer as TPO Participant T3 - Cannot Identify Insured as TPO Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing T6 - Claim does not contain enough information for repricing
		HCP14	Line Repricing Policy Compliance Code	S	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital

		HCP15	Line Repricing Exception Code	S	1/2	1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 - Other
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
416	2410	LIN01	Not Used by HIPAA			
		LIN03	National Drug Code or UPC	R	1/48	**N4** National Drug Code in 5-4-2 Addendum 222A1changed element name. **REQUIRED if PAD is administered by a physician not a pharmacy.**
		LIN04-LIN31				Not Used by HIPAA
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
426	2410	CTP01-CTP03	Not Used by HIPAA			
		CTP04	National Drug Unit Count	R	1/15	Quantity
		CTP05-1	Unit/Basis for Measurement	R	2/2	Basis of measurement for CTP04. F2 - International Unit GR – Gram ME – Milligram ML – Milliliter UN - Unit
		CTP05-2-CTP05-15	Not Used by HIPAA			
		CTP06-CTP11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
428	2410	REF01	Prescription Number Qualifier	R	2/3	VY - Link Sequence Number XZ - Pharmacy Prescription Number
		REF02	Prescription Number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
430	2420A	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider
		NM102	Entity Type Qualifier	R	1/1	**1 - Person** **2 - Non-Person**
		NM103	Service Line Rendering Provider Last/Organization Name	R	1/60	
		NM104	Service Line Rendering Provider First Name	S	1/35	
		NM105	Service Line Rendering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Service Line Rendering Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Rendering Provider Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
433	2420A	PRV01	Provider Code	R	1/3	**PE** Performing

		PRV02	Reference Identification Qualifier	R	2/3	**PXC** Provider Taxonomy Code
		PRV03	Service Line Rendering Provider Taxonomy Code	R	1/50	
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
434	2420A	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number **LU** Location number
		REF02	Service Line Rendering Provider Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
436	2420B	NM101	Entity Identifier Code	R	2/3	**QB** Purchase Service Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person 2 Non-Person Entity
		NM103-NM106	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Purchased Service Provider Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
439	2420B	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Service Line Purchased Service Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
441	2420C	NM101	Entity Identifier Code	R	2/3	**77** Service Facility last/organization name
		NM102	Entity Type Qualifier	R	1/1	**2** (Service Location)
		NM103	Service Line Service Facility Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Service Facility Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

444	2420C	N301	Service Facility Address 1	R	1/55	
		N302	Service Facility Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
445	2420C	N401	Service Facility City	R	2/30	
		N402	Service Facility State	S	2/2	
		N403	Service Facility Zip Code	S	3/15	
		N404	Service Facility Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Service Facility Sub-Country Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
447	2420C	REF01	Reference Identification Qualifier	R	2/3	**LU** Location Number. **G2** Provider commercial number
		REF02	Service Line Service Facility Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
449	2420D	NM101	Entity Identifier Code	R	2/3	**DQ** Supervising Physician
		NM102	Entity Type Qualifier	R	1/1	**1 -** Person
		NM103	Supervising Provider Last Name	R	1/60	
		NM104	Supervising Provider First Name	R	1/35	
		NM105	Supervising Provider Middle Name	R	1/25	
		NM106	Not Used by HIPAA			
		NM107	Supervising Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Supervising Provider Primary ID	S	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
452	2420D	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **LU** Location Number. **G2** Provider commercial number
		REF02	Supervising Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
454	2420E	NM101	Entity Identifier Code	R	2/3	**DK** Ordering Physician
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Ordering Provider Last Name	R	1/60	
		NM104	Ordering Provider First Name	R	1/35	
		NM105	Ordering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Ordering Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier		1/2	**XX** HIPAA National Provider ID
		NM109	Ordering Provider Primary ID	S	2/80	

		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
457	2420E	N301	Ordering Provider Address 1	R	1/55	
		N302	Ordering Provider Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
458	2420E	N401	Ordering Provider City	R	2/30	
		N402	Ordering Provider State	S	2/2	
		N403	Ordering Provider Zip Code	S	3/15	
		N404	Ordering Provider Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ordering Provider Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
460	2420E	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Ordering Provider Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record for REF01= G2			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
462	2420E	PER01	Contact Function Code	R		**IC**
		PER02	Ordering Provider Contact Name	S	1/60	
		PER04/06/08	Ordering Provider Telephone	S	1/80	**PER03/05/07 = TE**
		PER04/06/08	Ordering Provider Telephone Extension	S	1/80	**PER05/07 = EX**
		PER04/06/08	Ordering Provider Fax Number	S	1/80	**PER03/05/07 = FX**
		PER04/06/08	Ordering Provider Email Address	S	1/80	**PER03/05/07 = EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
465	2420F	NM101	Entity Identifier Code	S	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	S	1/1	**1** Person
		NM103	Referring Provider Last Name	S	1/60	
		NM104	Referring Provider First Name	S	1/35	
		NM105	Referring Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Referring Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier		1/2	**XX** HIPAA National Provider ID
		NM109	Referring Provider Primary ID XX	S	1/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
468	2420F	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Referring Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record for REF01= G2			COB Data.

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
465	2420F	NM101	Entity Identifier Code	R	2/3	**P3** Primary Care Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person. If not the primary care provider, this is the initial referring provider
		NM103	PCP Provider Last Name	S	1/60	
		NM104	PCP Provider First Name	S	1/35	
		NM105	PCP Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	PCP Provider Name Suffix	S	1/10	
		NM109	PCP Provider Primary ID XX	S	1/80	**XX** HIPAA National Provider ID
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
468	2420F	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	PCP Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
470	2420G	NM101	Entity Identifier Code		2/3	**PW** Pickup Up Address
		NM102	Entity Type Qualifier		1/1	**2** Non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
472	2420G	N301	Ambulance Pickup Address 1	R	1/55	
		N302	Ambulance Pickup Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
473	2420G	N401	Ambulance Pickup City	R	2/30	
		N402	Ambulance Pickup State	S	2/2	
		N403	Ambulance Pickup Zip Code	S	3/15	
		N404	Ambulance Pickup Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Pickup Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
475	2420H	NM101	Entity Identifier Code	R	2/3	**45** Drop off Location
		NM102	Entity Type Qualifier	R	1/1	**2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
477	2420H	N301	Ambulance Dropoff Address 1	R	1/55	
		N302	Ambulance Dropoff Address 2	S	1/55	
478	2420H	N401	Ambulance Dropoff City	R	2/30	
		N402	Ambulance Dropoff State	S	2/2	
		N403	Ambulance Dropoff Zip Code	S	3/15	
		N404	Ambulance Dropoff Country Code	S	2/3	

		N405 N406	Not Used by HIPAA			
		N407	Ambulance Dropoff Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
480	2430	SVD01	Other Payer Primary Identifier	R	2/80	Must match Loop 2330B NM109 REQUIRED to report PAID Amount
		SVD02	Service Line Paid Amount	R	1/18	Note: Zero is acceptable **NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV103 (Prof) Line Item Charge Amount. SVD02 must balance to a value greater than or equal to zero (0)**
		SVD03-1	Procedure Code Qualifier	R	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing (ABC) code
		SVD03-2	Procedure Code	R	1/48	
		SVD03-3	Procedure Code Modifier 1	S	2/2	
		SVD03-4	Procedure Code Modifier 2	S	2/2	
		SVD03-5	Procedure Code Modifier 3	S	2/2	
		SVD03-6	Procedure Code Modifier 4	S	2/2	
		SVD03-7	Procedure Code Description	S	1/80	
		SVD03-8 SVD04	Not Used by HIPAA			
		SVD05	Paid Service Unit Count	R	1/15	
		SVD06	Bundled or Unbundled Line Number	S	1/6	References the service line number which this line was bundled into.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
	2430	CAS01	Claim Adjustment Group Code	R	1/2	General category of payment adjustment: CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** NOTE: **Required to report non-zero Member Cost Share** and paid amount. When submitting Member Cost Share use code PR and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below
	2430	CAS02	Adjustment Reason Code	R	1/5	Line Adjustment Reason Code – Required Member Cost Share (PR qualifier), reason codes: **1 = Deductible Amount** **2 = Coinsurance Amount** **3 = Co-payment Amount** Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
	2430	CAS03	Monetary Amount	R	1/18	
	2430	CAS04	Quantity	S	1/5	Unit of Service
	2430	CAS05	Claim Reason Code	S	1/2	Line Adjustment Reason Code

	2430	CAS06	Monetary Amount	S	1/5	
	2430	CAS07	Quantity	S	1/5	Unit of Service
	2430	CAS08	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS09	Monetary Amount	S	1/5	
	2430	CAS10	Quantity	S	1/5	Units of service
	2430	CAS11	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS12	Monetary Amount	S	1/5	
	2430	CAS13	Quantity	S	1/5	Units of service
	2430	CAS14	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS15	Monetary Amount	S	1/5	
	2430	CAS16	Quantity	S	1/5	Units of service
	2430	CAS17	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS18	Monetary Amount	S	1/5	
	2430	CAS19	Quantity	S	1/5	Units of service
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
490	2430	DTP01	Date/Time Qualifier	R	3/3	**573** Date Claim Paid or Processed
		DTP02	Date Time Period Format Qualifier	R	2/3	**D8** Date Expressed in Format CCYYMMDD
		DTP03	Service Adjudication or Payment Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
491	2430	AMT01	Amount Qualifier Code		1/3	**EAF** (implied decimal) (Amount owed)
		AMT02	Remaining Patient Liability	R	1/18	
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
492	2440	LQ01	Form Identification Code	R	1/3	AS - Form Type Code UT - HCFA DMERC Certificate of Medical Necessity Forms
		LQ02	Form Identifier	R	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
494	2440	FRM01	Question Number/Letter	R	1/20	
		FRM02	Question Response	S	1/1	N - No W - Not Applicable Y - Yes
		FRM03	Question Response Text	S	1/50	
		FRM04	Question Response Date	S	8/8	
		FRM05	Question Response Percent	S	1/6	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
496	Transaction Set Trailer	SE01	Number of Included Segments	R	1/10	
		SE02	Transaction Set Control Number	S	4/9	

Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
C.9	Functional Group Trailer	GE01	Number of Transactional Sets Included	R	1/6	
		GE02	Group Control Number	S	1/9	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
C.10	Interchange Control Trailer	IEA01	Number of Included Functional Groups	R	1/5	
		IEA02	Interchange Control Number	S	9/9	

Appendix

EDITOR'S NOTE:
This page is blank because books should end on a left hand page.

非營業時間腳本範例

醫師和醫療團體可以使用下列腳本之一做為範本，確保即使在非營業時間或診所休診時間 Health Net 會員仍可及時取得醫療照護。

重要：在非營業時間提供有效率的電話服務可確保會員來電時能在 30 秒內接通電話服務人員或答錄機服務。

I. 電話服務人員接聽電話 (例如代客接聽電話服務或集中檢傷分類服務)：

如果來電會員認為自己發生醫療緊急情況，請告訴來電會員先掛斷電話，然後馬上撥 911 或前往最近的急診室 / 醫療機構。

如果來電會員認為情況緊急，或表示需要和醫師通話，請採取以下一項或多項動作，協助聯絡醫師：

- 暫時保留來電會員的電話，然後把來電會員轉接給待命醫師
- 留下來電會員的電話號碼，並告訴來電會員，醫師會在四小時內回電 (立即傳送訊息給醫師)
- 把待命醫師的傳呼號碼給來電會員，並告訴來電會員，醫師會在四小時內回會員電話；或指示來電會員前往最近的緊急照護中心
- 如果來電會員表示需要口譯服務，請使用口譯服務以協助聯絡

範例：

您好，這裡是<姓氏>醫師的<代客接聽電話服務 / 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請別掛斷，我會幫您轉接電話。

您好，這裡是<姓氏>醫師的<代客接聽電話服務 / 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，<姓氏>醫師可以協助您。請<傳呼 / 撥打> <電話號碼> 聯絡醫師。您應該會在四小時內接到回電。

II.答錄機接聽電話：

您好，這裡是 <輸入醫師姓名 / 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話 (選擇適當的選項)：

- *請稍候，我們會為您轉接<姓氏>醫師。*
- *您可以撥 <電話號碼> 直接聯絡待命醫師。*
- *請按 <號碼>，就可以轉接我們的緊急照護中心。我們緊急照護中心的地址是 <緊急照護中心地址> (應針對該地點提供適當的語言選項。)*
- *請按 <號碼>，就可以傳呼待命醫師。您應該會在四小時內接到回電。*

範例：

您好，這裡是 <醫師 / 醫療團體名稱> 的<姓氏>醫師。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請留下您的姓名、電話號碼，以及來電的原因，您應該會在四小時內接到回電。

您好，這裡是 <醫師姓名 / 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，您可以撥 <電話號碼> 或按 <號碼> 進行傳呼，就可以直接聯絡待命醫師。您應該會在四小時內接到回電。

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within four hours (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within four hours, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>. You may expect a call back within four hours.

II. CALLS ANSWERED BY AN ANSWERING MACHINE:

Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within four hours*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within four hours.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within four hours.

EJEMPLO DE TEXTO PARA USAR FUERA DEL HORARIO DE ATENCIÓN

Los médicos y grupos médicos pueden utilizar uno de los siguientes textos como plantilla para garantizar que los afiliados a Health Net tengan acceso a una atención médica oportuna fuera del horario de atención o cuando sus consultorios están cerrados.

IMPORTANTE: Un servicio telefónico eficaz fuera del horario de atención garantiza que las personas que llaman puedan comunicarse con una voz en vivo o un contestador automático dentro de los 30 segundos.

I. LLAMADAS RESPONDIDAS POR UNA VOZ EN VIVO (como un servicio de mensajes telefónicos o un servicio centralizado de clasificación según las prioridades de atención):

Si la persona que llama cree que está teniendo una emergencia médica, indíquele que cuelgue y que llame al 911 de inmediato, o bien, que se dirija a la sala de emergencias/al centro médico más cercano.

Si la persona que llama cree que la situación es de urgencia o indica que necesita hablar con un médico, póngala en contacto con el médico siguiendo uno o más de los pasos a continuación:

- Déjela en espera por un momento y luego comuníquela con el médico de guardia
- Solicítele el número de teléfono e indíquele que un médico le devolverá la llamada dentro de las cuatro horas (envíe un mensaje al médico de inmediato)
- Proporciónele el número del buscapersonas del médico de guardia e indíquele que el médico llamará al afiliado dentro de las cuatro horas, o bien, diríjala al centro de atención de urgencia más cercano
- Si una persona que llama indica que necesita servicios de intérprete, póngala en contacto con quien pueda brindarle dichos servicios

Ejemplos:
Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, permanezca en línea mientras le comunico.

Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, el Dr./la Dra. <Apellido> puede ayudarle. Por favor, <llámelo/a> al <número de teléfono>. Calcule que se le devolverá la llamada dentro de las cuatro horas.

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMÁTICO:

Hola, usted se ha comunicado con <insertar el nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia (seleccione la opción correspondiente):

- *Por favor, espere un momento mientras le comunico con el Dr./la Dra. <Apellido>*
- *Usted puede comunicarse directamente con el médico de guardia llamando al <número de teléfono>*
- *Oprima <número> para transferir la llamada a nuestro centro de atención de urgencia, que está ubicado en <dirección del centro de atención de urgencia> (Se deben proporcionar las opciones de idioma correspondientes a la ubicación.)*
- *Oprima <número> para llamar al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de las cuatro horas.*

Ejemplos:
Hola, usted se ha comunicado con <Nombre del Médico/Group Médico> para el Dr./la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, deje un mensaje con su nombre, su número de teléfono y el motivo por el que llama, y calcule que se le devolverá la llamada dentro de las cuatro horas.

Hola, usted se ha comunicado con <Nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, puede comunicarse directamente con éste llamando al <número de teléfono> u oprimiendo <número> para acceder al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de las cuatro horas.

Annual Care for Older Adults (COA) Form

Read Carefully

This form must be reviewed and signed by the physician or other provider. Please save a copy in the patient's medical records. This form is available in the Provider Library on Health Net's provider portal at provider.healthnetcalifornia.com > Provider Library under Forms and References, or go directly to providerlibrary.healthnetcalifornia.com.

Patient Name: _____ DOB: _____ /_____ /_____ ID #: _____

Date Vitals Collected: _____ /_____ /_____ Blood Pressure: _____ /_____

Functional Status Assessment (CPT II: 1170F)

Date Assessed: ___ /___ /___ ADLs Assessed? ☐ Yes ☐ No IADLs Assessed? ☐ Yes ☐ No

Was an FSA tool used: ☐ Yes ☐ No If YES, name of FSA tool _____
Score/Result_____

Pain Assessment (CPT II: 1125F, 1126F)

Date Assessed: _____ /_____ /_____ Does the patient have pain? ☐ Yes ☐ No

Medication List and Review (CPT II: 1159F and 1160F)
Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

This section must be reviewed and signed by prescribing provider or clinical pharmacist.

Date Reviewed: _____ /_____ /_____ Medication List attached: ☐

Patient not taking any medications: ☐

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print): _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____Date: _____ /_____ /_____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

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23-820a/FRM1188857EH01w (8/23)

Advance Care Planning (ACP) Form

Read Carefully

This form must be reviewed and signed by the physician or other provider. Please save a copy in the patient's medical records. This form is available in the Provider Library on Health Net's provider portal at provider.healthnetcalifornia.com > Provider Library under Forms and References, or go directly to providerlibrary.healthnetcalifornia.com.

Patient Name: _____ DOB: _____ /_____ / _____ ID #: _____

Advance Care Planning (CPT II: 1123F, 1124F, 1157F, 1158F)
Date discussed with Patient/Caregiver: _____ / _____ / _____ **Copy of Advance Care Plan in patient's chart:** ☐ Yes ☐ No Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders

Provider Name (Print): _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____Date: _____ /_____ /_____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

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23-820b/FRM1188857EH01w (8/23)

Formulario aprobado
OMB No. 0938-0950

NOMBRAMIENTO DE UN REPRESENTANTE

Nombre de la Parte	Numero de Medicare (beneficiario como parte) o Identificador Nacional del Proveedor (proveedor como parte)

SECCIÓN 1: NOMBRAMIENTO DE UN REPRESENTANTE

Para ser completado por la parte que busca representación (i.e., el beneficiario de Medicare, el proveedor o suplidor):

Yo nombro a _____ para actuar como representante en relación con mi reclamación o derecho en virtud del título XVIII de la Ley del Seguro Social (la "Ley") y sus disposiciones relacionadas al título XI de la Ley. Autorizo a este individuo a realizar cualquier solicitud; presentar u obtener pruebas; obtener información sobre apelaciones y recibir toda notificación sobre mi apelación, en mi representación. Entiendo que podría divulgarse la información médica personal sobre mi apelación al representante indicado a continuación.

Firma dela Parte Solicitando Representación		Fecha
Dirección		Número de Teléfono (Con Código de Area)
Ciudad	Estado	Código Postal

SECCIÓN 2: ACEPTACIÓN DEL NOMBRAMIENTO

Para ser completado por el representante:

Yo,_____, acepto por la presente el nombramiento antes mencionado. Certifico que no se me ha descalificado, suspendido o prohibido mi desempeño profesional ante el Departamento de Salud y Servicios Humanos (DHHS en inglés); que no estoy en calidad de empleado actual o anteriormente de los Estados Unidos, descalificado para actuar como representante del participante; y que reconozco que todo honorario podría estar sujeto a revisión y aprobación de la Secretaría.

Me desempeño como _____
(Situación profesional o relación con la parte, por ejemplo, abogado, pariente, etc.)

Firma del Representante		Fecha
Dirección		Número de Teléfono (Con Código de Area)
Ciudad	Estado	Código postal

SECCIÓN 3: RENUNCIA AL COBRO DE HONORARIOS POR REPRESENTACIÓN

Instrucciones: El representante debe completar esta sección si se lo requieren o si renuncia al cobro de honorarios por representación. (Los proveedores o suplidores que representen a un beneficiario y le hayan brindado artículos o servicios no pueden cobrar honorarios por representación y deben completar esta sección).

Renuncio a mi derecho de cobrar un honorario por representar a _____ ante el Secretario(a) del DHHS.

Firma	Fecha

SECCIÓN 4: RENUNCIA AL PAGO POR ARTÍCULOS O SERVICIOS EN CUESTIÓN

Instrucciones: Los proveedores o suplidores que actúan como representantes de beneficiarios a los que les brindaron artículos o servicios deben completar esta sección si la apelación involucra un tema de responsabilidad en virtud de la sección 1879(a)(2) de la Ley. (La sección 1879(a)(2) en general se aborda si un proveedor, suplidor o beneficiario no tenía conocimiento o no se podía esperar razonablemente que supiera que los artículos o servicios en cuestión no estarían cubiertos por Medicare).

Renuncio a mi derecho de cobrar al beneficiario un honorario por los artículos o servicios en cuestión en esta apelación si está pendiente una determinación de responsabilidad bajo la sección 1879(a)(2) de la Ley.

Firma	Fecha

Cobro de Honorarios por Representación de Beneficiarios ante El Secretario(a) del DHHS
Un abogado u otro representante de un beneficiario, que desee cobrar un honorario por los servicios prestados en relación con una apelación ante el Secretario(a) del DHHS (i.e., una audiencia con un Juez de Derecho Administrativo (ALJ en inglés), una revisión con el Consejo de Apelaciones de Medicare o un proceso ante un ALJ o el Consejo de Apelaciones de Medicare como resultado de una orden de remisión de la Corte de Distrito Federal) debe, por ley obtener aprobación para recibir un honorario de acuerdo con 42 CFR §405.910(f).

Mediante este formulario, "Solicitud para obtener un honorario por concepto de representación" se obtiene la información necesaria para solicitar el pago de honorario. Debe ser completado por el representante y presentado con la solicitud para audiencia con el ALJ o revisión del Consejo de Apelaciones de Medicare. La aprobación de honorarios para el representante no es necesaria si: (1) el apelante es representado por un proveedor o suplidor; (2) prestados en calidad oficial como un tutor legal, comité o cargo similar representante designado por el tribunal y con la aprobación del tribunal del honorario en cuestión; (3) el honorario es por representación del beneficiario ante la corte de distrito federal; o (4) el honorario es por representación del beneficiario en una redeterminación o reconsideración. Si el representante desea renunciar al cobro de un honorario, puede hacerlo. La sección 3 en la primera página de este formulario puede usarse para ese propósito. En algunas instancias, según se indica en el formulario, no se cobrará el honorario por concepto de representación.

Aprobación de Honorarios
El requisito para la aprobación de honorarios garantiza que el representante recibirá una remuneración justa por los servicios prestados ante DHHS en nombre de un beneficiario y brinda al beneficiario la seguridad de que los honorarios sean razonables. Para la aprobación de un honorario solicitado, el ALJ o el Consejo de Apelaciones de Medicare considera la clase y el tipo de servicios prestados, la complejidad del caso, el nivel de pericia y capacidad necesaria para la prestación de servicios, la cantidad de tiempo dedicado al caso, los resultados alcanzados, el nivel de revisión administrativa al cual el representante llevó la apelación y el monto del honorario solicitado por el representante.

Conflicto de Interés
Las secciones 203, 205 y 207 del título XVIII del Código de Estados Unidos consideran como un delito penal cuando ciertos funcionarios, empleados y antiguos funcionarios y empleados de los Estados Unidos prestan ciertos servicios en temas que afectan al Gobierno, ayudan o asisten en el procesamiento de reclamaciones contra los Estados Unidos. Los individuos con un conflicto de interés quedarán excluidos de ser representantes de los beneficiarios ante DHHS.

Dónde enviar este Formulario
Envíe este formulario al mismo lugar que está enviando (o ha enviado) su: apelación si está solicitando una apelación, queja si está solicitando una queja, o determinación o decisión inicial si está solicitando una determinación o decisión inicial. Si necesita ayuda, comuníquese con su plan de Medicare o llame al 1-800-MEDICARE (1-800-633-4227). Usuarios TTY debe llamar al 1-877-486-2048.

CMS no discrimina en sus programas o actividades. Para solicitar una esta publicación en un formato alterno, llame al 1-800-MEDICARE (TTY 1-877-486-2048) o envíe un correo electrónico a: AltFormatRequest@cms.hhs.gov.

De acuerdo con la Ley de Reducción de Papeleo de 1995, no se le requiere a ninguna persona responder a una recopilación de información a menos de que presente un número de control válido OMB. El número de OMB para esta recopilación es 0938-0950. El tiempo requerido para completar este formulario es de 15 minutos por notificación, incluyendo el tiempo necesario para seleccionar el formulario pre-impreso, completar y entregárselo al beneficiario. Si tiene comentarios sobre el tiempo estimado para completarlo o sugerencias para mejorar este formulario, favor de escribir a: CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Autoclave Maintenance and Run Log -- Year _____

Please Date and Initial

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
MONTHLY SPORE TESTING RESULTS												
MONTHLY CLEANING												
ANNUAL CALIBRATION												

Sterility is **EVENT related**, not time related; Pack is considers sterile unless and event causes contamination (example: punctured, torn, cracked packs = unsterile; evidence of water damage or yellowed packs = unsterile). Have process to routine evaluation of sterile packs
Log Process: Write date and Load # on Pack (if more than 1 load is run in the same day, write date and load #1 and then date and load #2 etc)

Date	Time	Load #	Item(s) Autoclaved	Temperature (250-254 Degrees)	Steam Pressure (15-17 psi)	Duration of Run (30 minutes)	Person Responsible

ACTIVITY ANALYSIS REPORT FIELD DESCRIPTIONS

Field	Description
Header Information	
Report BRM30	A Health Net-assigned number for the Activity Analysis Report
Report Title	The name of the report
Date	The day/month/year that the report was system generated
Page Number	The page number of the report
Provider ID	Three- or Four-digit number Health Net assigns to each PPG
Provider Name	Name of the PPG
Provider Address	Address of the provider.
Provider Phone Number	Phone Number of the provider.
Report Information	
Member Name	First, last and middle initial of the member
Member Sex Code	A single-digit code indicating the gender of the subscriber: • M= male • F= female
Member ID	Reports for commercial providers will have subscriber's ID/Ref ID number as shown on the Health Net ID card (usually the subscriber's Social Security number) Reports for medi-cal providers will have CIN Number(subscriber's client identification number)replaced for subscriber's ID/Ref ID
HIC Code ID #	The identification number assigned to the member by the Centers for Medicare and Medicaid Services (CMS)
Group ID #	A six-position code assigned to each employer group
Plan Code	A three-character code that identifies the medical plan of the employer group assigned by Health Net
Sat Prvd	The physician, satellite or provider ID of the member driven by the report (for example, site, hospital or consolidated)
Phy	The physician ID # of the member assigned by Health Net
Member risk	A single digit code for the member's risk status for Part A, Medicaid, member status, working aged, Medicaid Add-on, Disabled, Default Risk Factor & Dialysis Indicator (refer to Member Status Table below for values)
PIP / DCG Code	A two character code for PIP / DCG Code. It stands for principal inpatient diagnostic cost groups
SCC Code	State county code
Product code	A 3 or 4 position code that identifies the product type. Example, MDE, MLA, MCR, SDE, INDV
Age	The member's age at the end of the reporting month
Date of Birth	The member's date of birth
Dialysis Indicator	A one-position flag which indicate if member has dialysis
Member Eff Date / Can Date	The date the member became effective or canceled in this product
Activity	A two-positon code which indicates type of activity. Examples AC or RC or CA or PI or DI.
CIN#	A 9 character number for Cin Number
Aid code	A two-position code(either two numbers or a number and a

Field	Description
	letter), which assist providers in identifying the types of services for which Medi-Cal recipients are eligible.
Aid category	A 3-position code which identifies the Aid category code of a member.
Project code	A 3-position code which identifies the project code of a member.
Medicare part A flag	A one-position flag which indicate if member has Part A coverage(Hospital insurance)
Medicare part B flag	A one-position flag which indicate if member has Part B coverage(Medical insurance)
Medicare part D flag	A one-position flag which indicate if member has Part D coverage(outpatient Prescription Drug insurance)
Contract Type	A single-digit code indicating the member sex • M= male • F= female
Aid category Description	A 15 position description that identifies the aid category in which the member belongs.
Change Description	Describes the type of change that was made
Change Effective Date	The date capitation is being adjusted
Address	The member's home address, home telephone number, and work telephone numbers. This information is given when the change type is Add Contract, Add Member, Transfer In, Reinstate Contract, or Reinstate Member
PR TY	A single-letter code that identifies the product type of the member's employer group: • M = Standard HMO • N = POS HMO
Provider ID	The name of the PPG and the three- or four-digit number Health Net assigns to each PPG
Totals	
Adds	A summary count of member adds, reinstates and transfers-in processed in this period
Cancels	A summary count of member cancels and transfers-out processed in this period
Other Changes	The summary count of miscellaneous member transactions processed in this period
Net membership changes	A summary count of member adds minus member cancels transactions processed in this period

Member Status Table	
Field Name	**Values**
Medicare Part A Status	Y = Part A N = Part A Equivalent
Medicaid Status	Y = Yes N = No
Member Status	0 = Standard 1 = ESRD 2 = Hospice

	3 = Institutionalized
Working Aged	Y = Yes N = No
Medicaid Add-on	Y = Yes N = No
Disabled	Y = Yes N = No
Default Risk Factor	Y = Yes N = No
Dialysis Indicator	Y = Yes N = No

SPC_RPT_BRM_11_SITE HEALTH NET SENIORITY-PLUS CAPITATION 02/26/07
ELIGIBILITY SUMMARY REPORT BY GROUPS Page: 1
For the Period 03/07
By SITE

Provider ID: 0123
Provider: SAMPLE MEDICAL GROUP
/ MONTEREY PARK
Address: 012 SOUTH SAMPLE BLVD. SUITE 012
MONTEREY PARK, CA 01234

Phone Number: (012) 345-6789

Grp ID	Pr Ty	-- G R O U P N A M E --	Plan Code	--- Supplemental Benefits ---	Elig Mbrs
01234Q	M	SP: ABC	79Q	MHN	12
12345Y	M	SP: CDE	79Q	MHN CHI	4
234NPC	M	SP: EFG	81U	TPT MHN	1

SPC MEMBERS ELIGIBLE WITHIN PROVIDER AS OF MONTH-END: 17

SPC_RPT_BRM_20 HEALTH NET SENIORITY-PLUS CAPITATION
03/27/15
REMITTANCE DETAIL FOR THE MONTH
04/15 Page: 1
By SITE
Site ID: 999 Provider: MNNNNNNN HOSPITAL MMM
Phone Number: (999) 999-9999 Address: 99999 SAMPLE BLVD STE 999
UNKNOWN, CA 99999-9999

- - - M E M B E R S I N F O - - -	Group ID	Pr	Plan Ty	Risk* Code 1 2 3 4 5 6 7 8	Member SCC	PIP DCG	Date of Birth/ AGE	PHYS ID	TOTAL --Capitation and Adjustments-- Month	MONTH'S ** Description **	Amount♦
Last, First Name, M.I. Sex Mbr ID#											
CIN# AID COD PROJ CODE MCR-STAT/A B D AID-CATEG											
XXXXX, YYYYYY Z X X99999999 99XXX9 XX XX9 X X 9 X X X X X							99999				
01/01/XX 999999 01/XX XXXXXXXXXXX XXXXXXXXXX							999.99				

01/XX ** Subtotal 999.99

Total Retroactive: 0.00

Member's Net Capitation: 999.99

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*Member Risk Data: 1 = Part A Stat, [Values: Y = Part A, N = Part A Equivalent]
2 = Medicaid Stat, [Values: Y/N]
3 = Member Status, [Values: 0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized]
4 = Working Aged, 5 = Medicaid Add on, 6 = Prev Disabled, 7 = Default_risk [Values: Y/N]
8 = Dialysis_Ind [Values: Y/N]

SPC_RPT_BRM_20 HEALTH NET SENIORITY-PLUS CAPITATION
03/27/15
REMITTANCE DETAIL FOR THE MONTH
04/15 Page: 3
By SITE
Site ID: 999 Provider: MNNNNNNN HOSPITAL MMM
Phone Number: (999) 999-9999 Address: 99999 SAMPLE BLVD STE 999
UNKNOWN, CA 99999-9999

- - - M E M B E R S I N F O - - -	Group ID	Pr	Plan Ty	Risk* Code 1 2 3 4 5 6 7 8	Member SCC	PIP DCG	Date of Birth/ AGE	PHYS ID	TOTAL --Capitation and Adjustments-- Month	MONTH'S ** Description **	Amount♦
Last, First Name, M.I. Sex Mbr ID#											
CIN# AID COD PROJ CODE MCR-STAT/A B D AID-CATEG											
XXXXX, YYYYY Z X X99999999 99XXX9 XX XX9 X X 9 X X X X X							99999				
01/01/XX 999999 01/XX PROFESSIONAL CAPITATION							999.99				

01/XX ** Subtotal 999.99

Total Retroactive: 0.00

Member's Net Capitation: 999.99
*Member Risk Data: 1 = Part A Stat, [Values: Y = Part A, N = Part A Equivalent]
2 = Medicaid Stat, [Values: Y/N]
3 = Member Status, [Values: 0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized]
4 = Working Aged, 5 = Medicaid Add on, 6 = Prev Disabled, 7 = Default_risk [Values: Y/N]
8 = Dialysis_Ind [Values: Y/N]

SPC_RPT_BRM_20 HEALTH NET SENIORITY-PLUS CAPITATION 03/27/15
REMITTANCE DETAIL FOR THE MONTH 04/15 Page: 604
By SITE

Site ID: 999 Provider: MNNNNNNN HOSPITAL MMM
Phone Number: (999) 999-9999 Address: 99999 SAMPLE BLVD STE 999
UNKNOWN, CA 99999-9999

- - - M E M B E R S I N F O - - - Last, First Name, M.I.	Sex	Mbr ID#	ID#	Group Ty	Pr Code	Plan 1 2 3 4 5 6 7 8	Member Risk*	PIP SCC	Date of Birth/ AGE	TOTAL PHYS ID	MONTH'S Month	--Capitation and Adjustments-- ** Description **	Amount♦	CIN#	AID COD	PROJ CODE	MCR-STAT/A B D	AID-CATEG
Total Capitation for Provider: 999																		
											01/XX	PROFESSIONAL CAPITATION	999999.99					
											01/XX	PROFESSIONAL CAPITATION	999999.99					
											01/XX	PROFESSIONAL CAPITATION	999999.99					
											01/XX	PROFESSIONAL CAPITATION	999999.99					
											01/XX	QUALITY WITHHOLD PROFESSIONA	-9999.99					
											01/XX	GROSS CAPITATION	999999.99					
											01/XX	GROSS CAPITATION	999999.99					
											01/XX	GROSS CAPITATION	999999.99					
											01/XX	GROSS CAPITATION	999999.99					
											01/XX	NET CAPITATION	999999.99					
											01/XX	NET CAPITATION	999999.99					

SPC Total Capitation: 999,999.99
MDE Total Capitation: 999,999.99

MLA Total Capitation:	999,999.99
SNP Total Capitation:	999,999.99
Grand Total Capitation:	999,999.99

*Member Risk Data: 1 = Part A Stat, [Values: Y = Part A, N = Part A Equivalent]
2 = Medicaid Stat, [Values: Y/N]
3 = Member Status, [Values: 0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized]
4 = Working Aged, 5 = Medicaid Add on, 6 = Prev Disabled, 7 = Default_risk [Values: Y/N]
8 = Dialysis_Ind [Values: Y/N]

Care Management Referral Form

DIRECTIONS: Select the member's plan below and email or fax the completed referral.

- **CA Commercial (Ambetter HMO/PPO, Employer Group plans (HMO, PPO, POS)) and Medicare Employer Groups** – Email completed form to Case.Management.Referrals@healthnet.com or fax completed form to **800-745-6955**.
- **CA Medicare** (including Medicare Advantage) for shared risk non-delegated plans. – Email completed form to Medicare_CM@healthnet.com or fax completed form to **866-290-5957** for physical health care management. Note: For behavioral health care management, refer special needs plan members to MHN via email to mhn.snp@healthnet.com.
- **CA Medi-Cal** – Email completed form to **CASHP.ACM.CMA@healthnet.com** or fax completed form to **866-581-0540**.

☐ *URGENT Request* ☐ UC Blue & Gold Plan Member

Part 1: Referring Source

First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information

Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP Code:

Member phone number:

Member Diagnosis/Health Condition (check all that apply):

☐ Asthma
☐ Back pain
☐ Behavioral health
  ☐ Anxiety
  ☐ Autism
  ☐ Depression
  ☐ Other (specify) _____
☐ Bursitis/tendonitis
☐ CAD
☐ Cancer
☐ Carpal tunnel syndrome
☐ Clinical Trials
☐ COPD
☐ Cystic fibrosis
☐ Diabetes
☐ Fibromyalgia
☐ Frozen shoulder
☐ Golf/tennis elbow
☐ Heart failure
☐ Hemophilia
☐ Hepatitis
☐ High risk pregnancy
  Estimated date of delivery __/__/__
☐ HIV/AIDS
☐ Hypertension
☐ Kidney disease
☐ Migraine/tension headache
☐ Musculoskeletal
☐ Obesity-weight management
☐ Osteoarthritis
☐ Prematurity and/or developmental delay
☐ Rheumatoid arthritis
☐ Sickle cell
☐ Transplant
☐ Traumatic brain injury
☐ Other: _____

Please check if any of the following referral reasons apply to the member:

☐ Member needs assistance with palliative care: _____
☐ Concerned about high emergency room utilization or frequent hospitalizations.
☐ Exhaustion of benefits.
☐ Member needs assistance with behavioral health needs.
☐ Member needs assistance with medical equipment.
☐ Member needs assistance with resources for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
☐ Member needs education on prescriptions and compliance.
☐ Member needs education/support with managing his/her chronic condition(s).
☐ Member needs prenatal care education and support services.
☐ Member needs transportation to medical appointments.
☐ Safety concerns.
☐ Other (specify) _____

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Please use this page to provide additional information (as needed).

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Authorized Representative	Date
_____	_____
Type or Print Name	Name of Provider
_____	_____
Title	Address

Health Net (HMO SNP)

Chronic Condition Verification Form

health net
MEDICARE PROGRAMS

Provider name	

One of your patients has elected to enroll in a Health Net Chronic Special Needs Plan (C-SNP). In order to qualify for continued enrollment in this plan, CMS requires verification from a health care provider that the individual has been diagnosed with one or more of the plan-qualifying chronic conditions.

Patient information

Last name | First name | MI

Medicare ID (HICN) | Date of birth (M M D D Y Y Y Y)

Please verify the patient's qualifying conditions (check all that apply)

- ☐ Diabetes mellitus
- ☐ Chronic heart failure (CHF)
- ☐ Cardiac arrhythmia
- ☐ Coronary artery disease
- ☐ Chronic venous thromboembolic disorder
- ☐ Peripheral vascular disease

☐ Patient does not have any of the above chronic conditions documented in his or her chart.

Health Care Provider Attestation (can be completed by provider or office staff). I hereby attest that the above information is correct and noted in the patient's medical record.

Printed name | Title

Signature | Date (M M D D Y Y Y Y)

Please complete verbal or written verification within 48 hours of receipt.

You or your office staff may complete this verification by:

Phone: To provide verbal verification, please contact the Health Net Membership Attestation Unit toll-free at **1-800-431-9007**. From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

Fax: To provide written verification, please fax completed and signed verification form to **1-866-214-1992**.

Health Net office use only

Date rec'd. | Health Net rep. | Status

Health Net has a contract with Medicare to offer HMO SNP plans. Enrollment in a Health Net Medicare Advantage plan depends on the renewal of these contracts.

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SPANISH	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
CHINESE	注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711)。
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) 번으로 전화해 주십시오.
ARMENIAN	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք: 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
PERSIAN	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP) تماس بگیرید. 1-800-275-4737 (All Other HMO) (TTY: 711)
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
JAPANESE	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) まで、お電話にてご連絡ください。
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم. 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (مكبلا و مصلا فتا ه مقر: 711).
PUNJABI	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) 'ਤੇ ਕਾੱਲ ਕਰੋ।

MON-KHMER, CAMBODIAN	ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711)។
HMONG	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
HINDI	ध्यान दें: यदि आप हिंदी बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711). पर कॉल करें।
THAI	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711)

Clinical Policy: Measurement of Serum 1,25-dihydroxyvitamin D

Reference Number: CP.MP.152
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Vitamin D is metabolized in the liver to 25-hydroxyvitamin D [25(OH)D], (also known as calcidiol), and then in the kidney to 1,25-dihydroxyvitamin D [1,25(OH)2D], also known as calcitriol. 25(OH)D is the major circulating form of vitamin D while 1,25(OH)2D is the active form of vitamin D. In individuals at risk for vitamin D deficiency, the best method for determining a person's vitamin D status is to measure a 25(OH)D concentration. Measurement of 1,25(OH)2D is not useful for monitoring the vitamin D status, as it does not reflect vitamin D reserves.[1] This policy address when measurement of 1,25(OH)2D is appropriate and medically necessary.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that measurement of serum 1,25(OH)2D (CPT 82652) is **medically necessary** for monitoring certain conditions, such as acquired and inherited disorders of vitamin D and phosphate metabolism, including any of the following indications:

A. Chronic kidney disease;
B. Hereditary phosphate-losing disorders;
C. Oncogenic osteomalacia;
D. Pseudovitamin D-deficiency rickets;
E. Vitamin D-resistant rickets;
F. Chronic granuloma-forming disorders (e.g., sarcoidosis and some lymphomas).

II. It is the policy of health plans affiliated with Centene Corporation that measurement of serum 1,25(OH)2D for routine screening of average risk, asymptomatic individuals is **not medically necessary.**

Background

Vitamin D or calciferol, is a fat-soluble vitamin that plays an important role in calcium homeostasis and bone health. Vitamin D comes in two forms, D_2 and D_3. It is unique among hormones because the major source of vitamin D is exposure to natural sunlight. Very few foods naturally contain, or are fortified with, vitamin D, thus, the major cause of vitamin D deficiency is inadequate exposure to sunlight.

Vitamin D deficiency is defined by the Endocrine Society as a 25(OH)D below 20 ng/ml (50 nmol/liter). Vitamin D deficiency results in abnormalities in calcium, phosphorus, and bone metabolism. It causes a decrease in the efficiency of intestinal calcium and phosphorus absorption of dietary calcium and phosphorus, resulting in an increase in parathyroid hormone (PTH) levels. Secondary hyperparathyroidism maintains serum calcium in the normal range at

the expense of mobilizing calcium from the skeleton and increasing phosphorus wasting in the kidneys.

Screening for Vitamin D deficiency is recommended for individuals at risk, such as those with osteomalacia, osteoporosis, chronic kidney disease, hepatic failure, malabsoprtion syndromes, hyperparathyroidism, African-American and Hispanic children and adults, pregnant or lactating women, older adults with history of falls or non-traumatic fractures, obese children or adults (BMI greater than 30 kg/m^2), granuloma-forming disorders, and some lymphomas.[1]

Circulating 25(OH)D is the best indicator to monitor for vitamin D status as it is the main circulating form of vitamin D, and has a half-life of two to three weeks. In contrast, 1,25(OH)2D, has a much shorter half-life of about four hours, circulates in much lower concentrations than 25(OH)D, and is susceptible to fluctuations induced by PTH in response to subtle changes in calcium levels. Serum 1,25(OH)2D is frequently either normal or even elevated in those with vitamin D deficiency, due to secondary hyperparathyroidism.[1]

The Endocrine Society
The Endocrine Society recommends using the serum circulating 25-hydroxyvitamin D [25(OH)D] level, measured by a reliable assay, to evaluate vitamin D status in patients who are at risk for vitamin D deficiency and in whom a prompt response to optimization of vitamin D status could be expected. They note further, 1,25(OH)2D measurement does not reflect vitamin D status as levels are tightly regulated by serum levels of PTH, calcium, and phosphate. Serum 1,25(OH)2D does not reflect vitamin D reserves, and measurement of 1,25(OH)2D is not useful for monitoring the vitamin D status of patients. Serum 1,25(OH)2D is frequently either normal or even elevated in those with vitamin D deficiency, due to secondary hyperparathyroidism. Measurement of 1,25(OH)2D is useful in acquired and inherited disorders in the metabolism of 25(OH)D and phosphate, including chronic kidney disease, hereditary phosphate-losing disorders, oncogenic osteomalacia, pseudovitamin D-deficiency rickets, vitamin D-resistant rickets, as well as chronic granuloma-forming disorders such as sarcoidosis and some lymphomas.

United States Preventive Services Task Force (USPSTF)
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults.

American Congress of Obstetricians and Gynecologists
At this time, there is insufficient evidence to support a recommendation for screening all pregnant women for vitamin D deficiency. For pregnant women thought to be at increased risk of vitamin D deficiency, maternal serum 25-hydroxyvitamin D levels can be considered and should be interpreted in the context of the individual clinical circumstance.

Coding Implications
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CPT® Codes	Description
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A15.0-A15.9	Respiratory tuberculosis
C81.00-C81.99	Hodgkin lymphoma
C82.00-C82.99	Follicular lymphoma
C83.00-C83.99	Non-follicular lymphoma
C84.00-C84.99	Mature T/NK-cell lymphomas
C88.0-C88.9	Malignant immunoproliferative diseases and certain other B-cell lymphomas
D86.0-D86.9	Sarcoidosis
E20.00	Idiopathic hypoparathyroidism
E20.8	Other hypoparathyroidism
E21.0-E21.9	Hyperparathyroidism and other disorders of parathyroid gland
E55.0	Rickets, active
E83.30-E83.39	Disorder of phosphorus metabolism and phoshatases
E83.50-E83.59	Disorders of calcium metabolism
N18.1-N18.9	Chronic kidney disease (CKD)
N25.0	Renal osteodystrophy
P37.0	Congenital tuberculosis

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	11/17	12/17

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Important Reminder

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contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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Clinical Policy: Helicobacter Pylori Serology Testing

Reference Number: CP.MP.153
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Helicobacter pylori (H. pylori) is the most prevalent chronic bacterial infection and is associated with peptic ulcer disease, chronic gastritis, gastric adenocarcinoma, and gastric mucosa associated lymphoid tissue (MALT) lymphoma. Noninvasive tests for the diagnosis of H. pylori include urea breath testing (UBT), stool antigen testing, and serology.[1]

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that H. pylori serology testing is **not medically necessary** for diagnosing infection or evaluating treatment effectiveness.

Background

The most common causes of peptic ulcer disease (PUD) are H. pylori infection and use of nonsteroidal anti-inflammatory drugs (NSAIDs). H. pylori infection causes progressive functional and structural gastroduodenal damage.[4] Accurate diagnosis of H. pylori infection is a crucial part in the effective management of many gastroduodenal diseases. Several invasive and non-invasive diagnostic tests are available for the detection of H. pylori and each test has its usefulness and limitations in different clinical situations.[8]

Urea breath tests and stool antigen tests are the most widely used non-invasive tests for identifying H. pylori infection, as well as most accurate. In addition, they can be used to confirm cure. Serologic tests are a convenient but less accurate alternative and cannot be used to confirm cure.[2] Serology testing is useful in screening and epidemiological studies.[6] For patients without alarm symptoms (e.g., weight loss, progressive dysphagia, recurrent vomiting, evidence of gastrointestinal bleeding, or family history of cancer), noninvasive testing for H. pylori, with either carbon-13-labeled urea breath testing or stool antigen testing, is recommended as a first-line strategy.[4]

The urea breath test is the noninvasive test of choice for the diagnosis of H. pylori, with high sensitivity (95%) and specificity (95% to 100%) for the detection of active H. pylori infections.[4] Urea breath tests require the ingestion of urea labeled with the nonradioactive isotope carbon 13 or carbon 14. Specificity and sensitivity approach 100%. Urea breath testing is an option for test of cure and should be performed four to six weeks after completion of eradication therapy. Proton pump inhibitors (PPIs) must be stopped for at least two weeks before the test, and accuracy is lower in patients who have had distal gastrectomy.[2]

Stool antigen tests using monoclonal antibodies are as accurate as urea breath tests if a validated laboratory-based monoclonal test is used. Like urea breath tests, stool antigen tests detect only

active infection and can also be used as a test of cure. PPIs should be stopped for two weeks before testing, but stool antigen tests are not as affected by PPI use.[2]

Serologic antibody testing detects immunoglobulin G specific to H. pylori in serum and cannot distinguish between an active infection and a past infection.[2] Most common serologic tests are based on an enzyme-linked immunosorbent assay (ELISA) technology. As with any test, prevalence of the H. pylori infection and the pretest probability influence the positive or negative predictive values. Overall, where the prevalence of H. pylori infection and the pretest probability are low, the negative predictive value of a serologic test is high whereas false positives are more frequent, with the opposite in high prevalence/high pretest probability cases (i.e., the positive predictive value is high but there is increased prevalence of false negative results).[4] Antibody testing cannot be used as a test of cure.

American Society for Clinical Pathology
Serologic evaluation of patients to determine the presence/absence of H. pylori infection is no longer considered clinically useful. Alternative noninvasive testing methods (e.g., the urea breath test and stool antigen test) exist for detecting the presence of the bacteria and have demonstrated higher clinical utility, sensitivity, and specificity.

The American Gastroenterological Association (AGA)
The AGA no longer recommends serology-based testing for diagnosing infection or evaluating treatment effectiveness as it is unable to distinguish between active infection and previous exposure to H. pylori, does not confirm eradication and has a poor positive predictive value when compared to active infection tests such as the urea breath test or stool antigen test.[7]

The American College of Gastroenterology
All patients with active PUD, a past history of PUD (unless previous cure of H. pylori infection has been documented), low-grade gastric MALT lymphoma, or a history of endoscopic resection of early gastric cancer should be tested for H. pylori infection. In patients with uninvestigated dyspepsia who are under the age of 60 years and without alarm features, non-endoscopic testing for H. pylori infection is a consideration. Other indications to test patients for H. pylori infection may include, patients taking long-term low-dose aspirin, patients initiating chronic treatment with an NSAID, patients with unexplained iron deficiency anemia despite an appropriate evaluation and adults with idiopathic thrombocytopenic purpura. Any individual who tests positive should be offered eradication therapy.[3] Patients with a history of PUD who have previously been treated for H. pylori infection should undergo eradication testing with a urea breath test or fecal antigen test.[3]

Coding Implications
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Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
86677	Antibody; Helicobacter pylori

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	12/17	12/17

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Clinical Policy: Thryoid Hormones and Insulin Testing in Pediatrics

Reference Number: CP.MP.154
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Numerous essential metabolic functions are mitigated by hormones produced by, and affecting the thyroid, *e.g.*, thyroid stimulating hormone [TSH] and thryoxine [T4], as well as by insulin. This policy discusses the medical necessity requirements for the testing of these hormones.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that thyroid hormone testing in healthy, including obese but otherwise healthy, children (age ≥ 1 and ≤ 18) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.

II. It is the policy of health plans affiliated with Centene Corporation that insulin testing in healthy, including obese but otherwise healthy, children (age ≥ 1 and ≤ 18) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.

Background

The thyroid is an endocrine gland that regulates numerous metabolic processes through hormone secretion. Thyroid homeostasis is controlled through a complex feedback loop through the hypothalamus-pituitary-thyroid axis. Thyroxine (otherwise known as T4 due to the presence of four iodine molecules) is the major secretory hormone of the thyroid, and is converted into triiodothyronine (T3). Secretion of thyroxine by the thyroid is regulated by the concentration of thyroid stimulating hormone (TSH). TSH is generated by the pituitary gland and secreted in the bloodstream to generate a feedback loop with T4. Loss of the regulatory feedback cycle of the thyroid hormones could lead to hyperthyroidism and primary or secondary hypothyroidism.

Assessment of thyroid function can be achieved through the quantification of thyroid hormone levels. However, the appropriate clinical utilization of these tests has been a subject of concern in the recent literature.[1,2] For example in pediatrics, TSH and total T4 can be elevated in children who are overweight or obese, but it is not clear if this is a result or cause of obesity.[3,4,5] Therefore general screening may not provide actionable clinical information.[3-7]

The Endocrine Society Clinical Practice Guideline on pediatric obesity recommends against routine laboratory evaluations for endocrine etiologies of pediatric obesity unless the patient's stature and/or height velocity are attenuated (assessed in relationship to genetic/familial potential and pubertal stage. They also recommend against measuring insulin concentrations when evaluating children or adolescents for obesity. They note that although obesity is associated with insulin resistance/hyperinsulinemia, attempts to diagnose insulin resistance by measuring plasma insulin concentration or any other surrogate in the clinical setting has no merit because it has no diagnostic value. Fasting insulin concentrations show considerable overlap between insulin-

resistant and insulin-sensitive youths. Therefore, there is no well-defined cut point differentiating normal from abnormal and no universally accepted, clinically useful, numeric expression that defines insulin resistance, unlike for glucose or lipids. Moreover, measuring insulin is hampered by the lack of standardized insulin assays, and poor reproducibility of even the same assay. Further limitations include race/ethnicity-related differences in insulin concentrations due to differences in the metabolic clearance rate of insulin and the cross reactivity between insulin and proinsulin. In youths with Type 2 diabetes mellitus, despite severe deficiency in insulin secretion, fasting insulin concentrations are higher than in youths without diabetes. Importantly, fasting insulin concentrations are similar in youths who are obese with normal glucose tolerance vs impaired glucose tolerance, allowing for the possible danger of missing a diagnosis of impaired glucose tolerance if one uses fasting insulin concentrations as a screening tool. Because of these limitations, measuring plasma insulin concentrations remains a research tool with no clinical value for evaluation of obesity.[7]

Coding Implications

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Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2

CPT® Codes	Description
83525	Insulin; total
83527	Insulin; free
84436	Thyroxine; total
84439	Thyroxine; free
84443	Thyroid stimulating hormone (TSH)
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	Triiodothyronine T3; total (TT-3)
84481	Triiodothyronine T3; free
84482	Triiodothyronine T3; reverse

Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.

ICD-10-CM Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.3	Overweight

ICD-10-CM Code	Description
E66.8	Other obesity
E66.9	Obesity, unspecified
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.8	Encounter for other general examination
Z68.52	Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53	BMI pediatric, 85th percentile to less than 95th percentile for age
Z68.54	BMI pediatric, greater than or equal to 95th percentile for age

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	12/17	12/17

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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Clinical Policy: EEG in the Evaluation of Headache

Reference Number: CP.MP.155
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
An electroencephalogram (EEG) is a non-invasive method for assessing neurophysiological function. EEG measures the electrical activity that is recorded from many different standard sites on the scalp according to the international (10 to 20) electrode placement system. It is a useful diagnostic test in evaluating epilepsy. This policy addresses the use of EEG in the diagnostic evaluation of headache.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that an EEG in the routine evaluation of headache is **not medically necessary.** EEG has not been convincingly shown to identify headache subtypes, nor has it been shown to be an effective screening tool for structural causes of headache.

Background
An EEG is an important diagnostic test in the evaluation of a patient with possible epilepsy, providing evidence that helps confirm or refute the diagnosis, as well as guide management. An EEG may be also be performed for other indications, including but not limited to, states of altered consciousness, cerebral infections, and various other encephalopathies.

Headache is a common disorder with many potential causes. The primary headaches, which include migraine, tension-type headache and cluster headache, are benign and account for the majority of headaches. They are usually recurrent and have no organic disease as their cause. Secondary headaches, are less common and caused by underlying organic diseases ranging from sinusitis to subarachnoid hemorrhage.[3] In most instances, the physician can accurately diagnose a patient's headache and determine whether additional laboratory testing or neuroimaging is indicated by considering the various headache types in each category (primary or secondary), obtaining a thorough headache history and performing a focused clinical examination.[4]

The presence of warning signs of a possible disorder, other than primary headache, that should prompt further investigation (e.g. limited laboratory testing, neuroimaging, lumbar puncture) include:

- Subacute and/or progressive headaches that worsen over time (months)
- A new or different headache
- Any headache of maximum severity at onset
- Headache of new onset after age 50
- Persistent headache precipitated by a Valsalva maneuver
- Evidence such as fever, hypertension, myalgias, weight loss or scalp tenderness suggesting a systemic disorder
- Presence of neurological signs that may suggest a secondary cause

- Seizures

Studies designed to determine whether headache patients have an increased prevalence of EEG abnormalities report conflicting results. The American Academy of Neurology reports that EEG has no advantage over clinical evaluation in diagnosing headache, does not improve outcomes, and increases costs. A literature review of 40 articles describing EEG findings in headache patients reported that studies did not show that the EEG is an effective screen for structural causes of headache, nor does the EEG effectively identify headache subgroups with different prognoses.[5]

American Academy of Neurology (AAN)
AAN reports that no study has consistently demonstrated that the EEG improves diagnostic accuracy for the headache sufferer. The AAN makes the following recommendations:

- The EEG is not useful in the routine evaluation of patients with headache (guideline). This does not exclude the use of EEG to evaluate headache patients with associated symptoms suggesting a seizure disorder, such as atypical migrainous aura or episodic loss of consciousness. Assuming head imaging capabilities are readily available, EEG is not recommended to exclude a structural cause for headache (option).[1]
- EEG is not recommended in the routine evaluation of a child with recurrent headaches, as it is unlikely to provide an etiology, improve diagnostic yield, or distinguish migraine from other types of headaches (Level C; class II and class III evidence).[2]
- Although the risk for future seizures is negligible in children with recurrent headache and paroxysmal EEG, future investigations for epilepsy should be determined by clinical follow up (Level C; class II and class III evidence).[2]

International Headache Society
The EEG is not included in the diagnostic criteria of the International Headache Society for migraine or any other major headache categories.

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Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10-CM in Table 2

CPT® Codes	Description
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813	Electroencephalogram (EEG) extended monitoring; greater than 1 hour

CPT® Codes	Description
95816	Electroencephalogram (EEG); including recording awake and drowsy
95819	Electroencephalogram (EEG); including recording awake and asleep

HCPCS Codes	Description
N/A	

Table 2: ICD-10-CM codes not medically necessary when billed with a corresponding CPT code in Table 1.

ICD-10-CM Code	Description
G43.00-G43.919	Migraine
G44.001-G44.89	Other headache syndromes
R51	Headache

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	12/17	12/17

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Clinical Policy: Cardiac Biomarker Testing for Acute Myocardial Infarction

Reference Number: CP.MP.156
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The release of cardiac biomarkers is among the cascade of events that occur during acute coronary syndromes and cardiac ischemia. This policy discusses the medical necessity requirements for testing of these cardiac biomarkers.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that troponin I or T testing is **medically necessary** for suspected acute myocardial infarctions (AMI).

II. It is the policy of health plans affiliated with Centene Corporation® that creatine kinase myocardial isoenzyme (CK-MB) and myoglobin testing are **not medically necessary** for suspected AMI because these tests have not been demonstrated to have a clear clinical benefit.

Background

Detection of specific cardiac biomarkers in blood serum is a useful clinical indication of AMI, myocarditis, or heart failure. According to the 2014 clinical practice guideline of the American College of Cardiologists / American Heart Association, (ACC/AHA) cardiac troponins have become the main biomarkers used for the diagnoses of acute coronary syndromes, specifically troponins I and T because these subunits are expressed in the myocardium.[1,2] Furthermore, troponin levels are also elevated for acute and chronic decompensated heart failure in instances of myocyte injury and/or necrosis.[3]

Other cardiac peptides that were previously assessed for AMI include CK-MB and myoglobin. However, recent evidence suggests that the sensitivity and specificity of these biomarkers are inferior compared to the troponins, suggesting that troponins are a more accurate biomarker of myocardial injury.[1] According to the 2014 ACC/AHA clinical practice guideline, CK-MB and myoglobin are no longer necessary for acute coronary syndrome diagnosis as a result of the advent of troponin assays.[1] CK-MB detection is comparatively less sensitive and less specific. Voltz et al. performed a retrospective cohort study across 55,000 emergency department visits for AMI and examined their CK-MB and troponin levels with screenings; the authors concluded that CK-MB can be omitted during the initial screening of AMIs.[6] Eggers et al, evaluated the role of myoglobin with troponin I to detect AMI in a sample of 197 patients and determined that neither myoglobin nor CK-MB added clinical diagnostic value.[4] Aviles et al analyzed AMI amongst patients with elevated cardiac troponins in a prospective cohort and noted that at least 20% of patients had normal CK-MB levels, thereby further questioning the validity of CK-MB as a valuable cardiac biomarker.[7] Of note, Singh *et al*. measured CK-MB testing from 2007 to 2013 and found a dramatic decrease from 12,057 tests in 2007 to 36 tests in 2013.[5]

Coding Implications

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Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2

CPT® Codes	Description
82553	Creatine kinase (CK), (CPK); MB fraction only
83874	Myoglobin

Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.

ICD-10-CM Code	Description
I20.0	Unstable angina
I20.1	Angina pectoris with documented spasm
I20.8	Other forms of angina pectoris
I20.9	Angina pectoris, unspecified
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I21.02	STEMI myocardial infarction involving left anterior descending coronary artery
I21.09	STEMI myocardial infarction involving other coronary artery of anterior wall
I21.11	STEMI myocardial infarction involving right coronary artery
I21.19	STEMI myocardial infarction involving other coronary artery of inferior wall
I21.21	STEMI myocardial infarction involving left circumflex coronary artery
I21.29	STEMI myocardial infarction involving other sites
I21.3	STEMI myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I21.9	Acute myocardial infarction, unspecified
I21.A1	Myocardial infarction type 2
I21.A9	Other myocardial infarction type
I22.0	Subsequent STEMI myocardial infarction of anterior wall
I22.1	Subsequent STEMI myocardial infarction of inferior wall
I22.2	Subsequent NSTEMI myocardial infarction
I22.8	Subsequent STEMI myocardial infarction of other sites
I22.9	Subsequent STEMI myocardial infarction of unspecified site

ICD-10-CM Code	Description
I23.7	Postinfarction angina
I24.0	Acute coronary thrombosis not resulting in myocardial infarction
I24.8	Other forms of acute ischemic heart disease
I24.9	Acute ischemic heart disease, unspecified
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
I25.2	Old myocardial infarction
I25.41	Coronary artery aneurysm
I25.42	Coronary artery dissection
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.700	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris
I25.701	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris
I25.709	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris
I25.710	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris
I25.720	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris

ICD-10-CM Code	Description
I25.730	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris
I25.750	Atherosclerosis of native coronary artery of transplanted heart with unstable angina
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm
I25.758	Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris
I25.759	Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris
I25.760	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
I25.761	Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm
I25.768	Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris
I25.769	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris
I25.790	Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris
I25.791	Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.798	Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris
I25.799	Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris
I25.810	Atherosclerosis of coronary artery bypass graft(s) without angina pectoris
I25.811	Atherosclerosis of native coronary artery of transplanted heart without angina pectoris
I25.812	Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris
I25.82	Chronic total occlusion of coronary artery
I25.83	Coronary atherosclerosis due to lipid rich plaque
I25.84	Coronary atherosclerosis due to calcified coronary lesion
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
R07.0	Pain in throat

ICD-10-CM Code	Description
R07.1	Chest pain on breathing
R07.2	Precordial pain
R07.81	Pleurodynia
R07.82	Intercostal pain
R07.89	Other chest pain
R07.9	Chest pain, unspecified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	12/17	12/17

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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Clinical Policy: 25-hydroxyvitamin D Testing in Children and Adolescents

Reference Number: CP.MP.157
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

A global consensus statement recommends against universal screening for vitamin D deficiency in healthy children as there is insufficient evidence that the potential benefits of testing outweigh the potential harms.[2]

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that 25-hydroxyvitamin D testing in healthy, including obese but otherwise healthy, children (age ≥ 1 and ≤ 18) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.

Background

Measurement of 25-OH-D (25-hydroxyvitamin D) concentration is the appropriate screening test for vitamin D deficiency, as opposed to 1,25-OH_2-D, which has little to no predictive value related to bone health.[6] However, there is lack of agreement concerning the best type of assay to conduct when measuring 25-hydroxyvitamin D.[4] Furthermore, there is substantial controversy concerning cutoff levels to define vitamin D deficiency, as the evidence is inconsistent regarding optimal levels of vitamin D.[1]

Prevalence of vitamin D deficiency in children (defined in the study as levels < 20 ng/mL) is estimated to be about 14%, although estimates range from 14% to 37%.[3,6] Rates of deficiency vary among certain populations, with increased risk among black and Hispanic teenagers, as well as overweight and obese children and adolescents.[6] Reduced serum vitamin D in overweight and obese children and adolescents reflects sequestration in adipose tissue, but little is known about the significance of low serum vitamin D in this population.[4]

A global consensus of 33 experts, convened at the request of the European Society for Pediatric Endocrinology, reviewed the available literature on prevention and management of nutritional rickets, and determined that routine vitamin D screening is not recommended for healthy children.[2] They note the frequent coexistence of dietary calcium and vitamin D deficiency, which alters the threshold for development of rickets, and makes a single screening value impractical.[2] The global consensus panel advocates for identification and screening of groups at high risk for vitamin D deficiency based on clinical factors, as opposed to universal screening as public health policy.

The American Academy of Pediatrics (AAP) – Section on Endocrinology advises against ordering vitamin D concentrations routinely in otherwise healthy children, including children who are overweight or obese.[5] The AAP's report on optimizing bone health recommends

screening for vitamin D deficiency only in children and adolescents with conditions associated with reduced bone mass and/or recurrent low-impact fractures.[6]

For healthy children and adolescents who are not ingesting enough foods with vitamin D, the AAP recommends supplementation with vitamin D, as does the global consensus panel convened by the European Society for Pediatric Endocrinology.

Coding Implications

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Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2

CPT® Codes	Description
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed

Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.

ICD-10-CM Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.8	Encounter for other general examination
Z68.52	Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53	BMI pediatric, 85th percentile to less than 95th percentile for age
Z68.54	BMI pediatric, greater than or equal to 95th percentile for age

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	12/17	12/17

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2. Munns CF, Shaw N, Kiely M, Specker BL, Thacher TD, et al. Global Consensus Recommendation on Prevention and Management of Nutritional Rickets. J Clin Endocrinol Metab. 2016 Feb;101(2):394-415. Co-Published in Horm Res Paediatr. 2016;85(2):83-106.
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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available 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 this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Clinical Policy: Ultrasound in Pregnancy

Reference Number: CP.MP.38
Last Review Date: 06/18

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy outlines the medical necessity criteria for ultrasound use in pregnancy. Ultrasound is the most common fetal imaging tool used today. Ultrasound is accurate at determining gestational age, fetal number, viability, and placental location; and is necessary for many diagnostic purposes in obstetrics. The determination of the time and type of ultrasound should allow for a specific clinical question(s) to be answered. Ultrasound exams should be conducted only when indicated and must be appropriately documented.

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that the following ultrasounds during pregnancy are considered **medically necessary** when the following conditions are met:

I. Standard first trimester ultrasound (76801)
II. Standard second or third trimester ultrasound (76805)
III. Detailed anatomic ultrasound (76811)
IV. Transvaginal ultrasound (76817)
V. Not medically necessary conditions

I. One standard *first trimester ultrasound (76801)* is allowed per pregnancy.

Subsequent standard first trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

II. One standard *second or third trimester ultrasound (76805)* is allowed per pregnancy.

Subsequent standard second or third trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

III. One *detailed anatomic ultrasound (76811)* is allowed per pregnancy when performed to evaluate for suspected anomaly based on history, laboratory abnormalities, or clinical evaluation; or when there are suspicious results from a limited or standard ultrasound. Further indications include the possibility of fetal growth restriction and multifetal gestation. This ultrasound must be billed with an appropriate high risk diagnosis code from Table 4 below.

A second detailed anatomic ultrasound is considered **medically necessary** if a new maternal fetal medicine specialist group is taking over care, a second opinion is required, or the patient

has been transferred to a tertiary care center in anticipation of delivery of an anomalous fetus requiring specialized neonatal care.

Further anatomic ultrasounds are considered **not medically necessary** as there is inadequate evidence of the clinical utility of multiple detailed fetal anatomic examinations.

IV. *Transvaginal ultrasounds (TVU)* are considered **medically necessary** when conducted in the first trimester for the same indications as a standard first trimester ultrasound, and later in pregnancy to assess cervical length, location of the placenta in women with placenta previa, or after an inconclusive transabdominal ultrasound. Cervical length screening is conducted for women with a history of preterm labor or to monitor a shortened cervix based on Table 1 below. Up to 12 transvaginal ultrasounds are allowed per pregnancy.

Table 1: Berghella approach to TVU measurement of cervical length for screening singleton gestations

Past pregnancy history	TVU cervical length screening	Frequency	Maximum # of TVU
Prior preterm birth 14 to 27 weeks	Start at 14 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	6
Prior preterm birth 28 to 36 weeks	Start at 16 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	5
No prior preterm birth	One exam between 18 and 24 weeks	Once	1

* Increase frequency to weekly in women with TVU cervical length of 25 to 29 mm. If <25 mm before 24 weeks, consider cerclage.

V. 3D and 4D ultrasounds are considered investigational and are therefore **not medically necessary**. Studies lack sufficient evidence that they alter management over two-dimensional ultrasound in a fashion that improves outcomes.

The following additional procedures are considered **not medically necessary**:

- Ultrasounds performed solely to determine the sex of the fetus or to provide parents with photographs of the fetus;
- Scans for growth evaluation performed less than 2 weeks apart;
- Ultrasound to confirm pregnancy in the absence of other indications;
- A follow-up ultrasound in the first trimester in the absence of pain or bleeding.

Classifications of fetal ultrasounds include:

I. Standard First Trimester Ultrasound - 76801

A standard first trimester ultrasound is performed before 14 weeks and 0 days of gestation. It can be performed transabdominally, transvaginally, or transperineally. When performed transvaginally, CPT 76817 should be used. It includes an evaluation of the presence, size, location, and number of gestational sac(s); and an evaluation of the gestational sac(s).

Indications for a first trimester ultrasound include the following:

- To confirm an intrauterine pregnancy

- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose and evaluate multiple gestations
- To confirm cardiac activity
- As adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in high risk patients
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy (nuchal translucency) when a part of aneuploidy screening
- To evaluate suspected hydatidiform mole

II. Standard Second or Third Trimester Ultrasound - 76805

A standard ultrasound in the second or third trimester involves an evaluation of fetal presentation and number, amniotic fluid volume, cardiac activity, placental position, fetal biometry, and an anatomic survey.

Indications for a standard second or third trimester ultrasound include the following**:**

- Screening for fetal anomalies
- Evaluation of fetal anatomy
- Estimation of gestational age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Evaluation of suspected multiple gestation
- Adjunct to amniocentesis or other procedure
- Evaluation of discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Examination of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of suspected ectopic pregnancy
- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation of fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation of prelabor rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa

- Evaluation with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment for findings that may increase the risk of aneuploidy

III. Detailed Anatomic Ultrasound - 76811

A detailed anatomic ultrasound is performed when there is an increased risk of an anomaly based on the history, laboratory abnormalities, or the results of the limited or standard ultrasound.

IV. Other Ultrasounds – 76817

A transvaginal ultrasound of a pregnant uterus can be performed in the first trimester of pregnancy and later in a pregnancy to evaluate cervical length and the position of the placenta relative to the internal cervical os. When this exam is done in the first trimester, the same indications for a standard first trimester ultrasound, 76801, apply.

Background

The Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS) trial showed that routine U/S screening of a low risk population did not lead to improved perinatal outcomes. This was a practice based, multi-center randomized trial. There were no significant differences in birth weight or preterm delivery rates.

Ultrasound is used most often in pregnancy for the estimation of gestational age. It has been shown that the use of multiple biometric parameters can allow for accuracy to within 3-4 days in a mid-trimester study (14-22 weeks). Accurate dating of a pregnancy is crucial as many important decisions might be made based on this date—whether or not to resuscitate an infant delivered prematurely, when to give antenatal steroids, when to electively deliver a term infant, and when to induce for post-dates.

Pregnancy dating with a first trimester or mid-trimester ultrasound will reduce the number of misdated pregnancies and subsequent unnecessary inductions for post-dates pregnancies. Third trimester ultrasounds for pregnancy dating are much less dependable.

Ultrasound is a helpful tool for the evaluation of fetal growth in at-risk pregnancies and the diagnosis of a small-for-gestational age baby (SGA). Those SGA babies with actual chronic hypoxemia and/or malnutrition can be termed growth restricted (FGR) if it is suspected that their growth has been less than optimal.

ACOG does not yet recommend the use of three- or four-dimensional ultrasound as a replacement for any necessary two-dimensional study. ACOG states “the technical advantages of three-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by two-dimensional ultrasonography. Despite these technical advantages, proof of a clinical advantage of three-dimensional ultrasonography in prenatal diagnosis in general still is lacking.”

The Society of Maternal Fetal Medicine specifically addresses what is often considered a level II screening U/S or routine U/S, stating:

"CPT 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it is intended for a known or suspected fetal anatomic or genetic abnormality (i.e., previous anomalous fetus, abnormal scan this pregnancy, etc.). Thus, the performance of CPT 76811 is expected to be rare outside of referral practices with special expertise in the identification of, and counseling about, fetal anomalies.

It is felt by all organizations involved in the codes development and description that only one medically indicated CPT 76811 per pregnancy, per practice is appropriate. Once this detailed fetal anatomical exam (76811) is done, a second one should not be performed unless there are extenuating circumstances with a new diagnosis. It is appropriate to use CPT 76811 when a patient is seen by another maternal-fetal medicine specialist practice, for example, for a second opinion on a fetal anomaly, or if the patient is referred to a tertiary center in anticipation of delivering an anomalous fetus at a hospital with specialized neonatal capabilities.

Follow-up ultrasound for CPT 76811 should be CPT 76816 when doing a focused assessment of fetal size by measuring the BPD [biparietal diameter], abdominal circumference, femur length, or other appropriate measurements, OR a detailed re-examination of a specific organ or system known or suspected to be abnormal. CPT 76805 would be used for a fetal maternal evaluation of the number of fetuses, amniotic/chorionic sacs, survey of intracranial, spinal, and abdominal anatomy, evaluation of a 4-chamber heart view, assessment of the umbilical cord insertion site, assessment of amniotic fluid volume, and evaluation of maternal adnexa when visible when appropriate."

Coding Implications

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Table 2: CPT® Codes Covered When Supported by Appropriate Diagnosis

CPT Codes	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 day), transabdominal approach; single or first gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥14 weeks 0 day), transabdominal approach; single or first gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal

CPT Codes	Description
	approach; single or first gestation
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

Table 3: CPT Codes considered Not Medically Necessary:

CPT Codes	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation
76377	requiring image post-processing on an independent workstation

Table 4: ICD-10 Diagnosis Codes that Support Medical Necessity for First Detailed Fetal Ultrasound

ICD-10-CM Code	Description
B06.00 – B06.9	Rubella [German measles]
B50.0 – B54	Malaria
B97.6	Parvovirus as the cause of diseases classified elsewhere
E66.01	Morbid (severe) obesity due to excess calories [severe obesity with a BMI of 35 or >]
O09.511 – O09.519	Supervision of elderly primigravida
O09.521 – O09.529	Supervision of elderly multigravida
O09.811 – O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O24.011 – O24.019, O24.111 – O24.119, O24.311 – O24.319, O24.811 – O24.819, O24.911 – O24.919	Diabetes mellitus in pregnancy
O30.001 – O30.099	Twin pregnancy
O30.101 – O30.199	Triplet pregnancy
O30.201 – O30.299	Quadruplet pregnancy
O30.801 – O30.899	Other specified multiple gestation
O31.10x+ - O31.23x+	Continuing pregnancy after spontaneous abortion / intrauterine death of one fetus or more
O33.6xx+	Maternal care for disproportion due to hydrocephalic fetus
O33.7xx+	Maternal care for disproportion due to other fetal deformities
O35.0xx+	Maternal care for (suspected) central nervous system malformation in fetus
O35.1xx+	Maternal care for (suspected) chromosomal abnormality in fetus
O35.2xx+	Maternal care for (suspected) hereditary disease in fetus

ICD-10-CM Code	Description
O35.3xx+	Maternal care for (suspected) damage to fetus from viral disease in mother
O35.4xx+	Maternal care for (suspected) damage to fetus from alcohol
O35.5xx+	Maternal care for (suspected) damage to fetus by drugs
O35.6xx+	Maternal care for (suspected) damage to fetus by radiation
O35.8xx+	Maternal care for other (suspected) fetal abnormality and damage
O35.9xx+	Maternal care for (suspected) fetal abnormality and damage, unspecified
O36.011+ - O36.099+	Maternal care for rhesus isoimmunization
O36.111+ - O36.199+	Maternal care for other isoimmunization
O36.511+ - O36.599+	Maternal care for other known or suspected poor fetal growth
O40.1xx+ - O40.9xx+	Polyhydramnios
O41.00x+ - O41.03x+	Oligohydramnios
O69.81x+ - O69.89x+	Labor and delivery complicated by other cord complications
O71.9	Obstetric trauma, unspecified
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O98.311 – O98.319, O98.411 – O98.419, O98.511 – O98.519, O98.611 – O98.619, O98.711 – O98.719, O98.811 – O98.819	Other maternal infectious and parasitic diseases complicating pregnancy
O99.320 – O99.323	Drug use complicating pregnancy
O99.411 – O99.419	Diseases of the circulatory system complicating pregnancy
Q04.8	Other specified congenital malformations of brain [choroid plexus cyst]
Q30.1	Agenesis and underdevelopment of nose [absent or hypoplastic nasal bone]
Q62.0	Congenital hydronephrosis [fetal pyelectasis]
Q71.811 – Q71.819	Congenital shortening of upper limb [humerus]
Q72.811 – Q72.819	Congenital shortening of lower limb [femur]
Q92.0 – Q92.9	Other trisomies and partial trisomies of the autosomes, not elsewhere classified [fetuses with soft sonographic markers of aneuploidy]
R93.5	Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum
R93.8	Abnormal findings on diagnostic imaging of other specified body structures
Z68.35 – Z68.45	Body mass index (BMI) 35.0 – 70 or greater, adult

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created & reviewed by Obstetrical specialist	01/11	01/11
Reviewed with no changes Obstetrical specialist reviewed	02/12	03/12
Reviewed with no changes	04/13	05/13
Nuchal translucency removed Divided criteria into first and second trimester Added indications for transvaginal ultrasound Obstetrical specialist reviewed	05/14	08/14
Reformatted policy Added ICD-9 and ICD-10 codes for when a standard ultrasound would be appropriate Obstetrical specialist reviewed Removed prior authorization language	08/15	08/15
Removed ICD-9 codes	11/15	
Added follow-up ultrasound as an alternative in Policy/Criteria sections I and II	02/16	
Reviewed with no criteria changes.	08/16	08/16
Allowed up to 6 TVU per pregnancy and added ICD-10 codes indicating when > 6 TVUs are appropriate	11/16	
Added to ICD-10 code list for standard ultrasounds: O02.0 – O02.9, O03.9, O28.0 – O28.9, Z32.01	01/17	
Removed ICD-10 code tables for 76801 and 76805, and 76817 No diagnosis code limitations in place for these codes. 76817 frequency over time changed to 12 from 6	05/17	
Added that transperineal u/s can be appropriate for a standard first trimester ultrasound scan per updated ACOG guidelines. Added "possibility of fetal growth restriction and multifetal gestation" to indications for detailed ultrasound in section III. Added "as an adjunct to embryo transfer" as an indication for standard first trimester ultrasound in "classifications of fetal ultrasound" section I. Added "The maternal cervix and adnexa are examined as clinically appropriate and when feasible" to description of standard second or third trimester ultrasound in "classifications of fetal ultrasound" section II. Minor wording clarifications made to criteria throughout policy to ensure consistency with latest ACOG practice bulletin for Ultrasound in Pregnancy, No. 175.	08/17	08/17
Removed – in the primary diagnosis position from section III as this is not a requirement for the edit.	12/17	
Added code range O30.801 – O30.899 to Table 4. References reviewed and updated.	06/18	06/18

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available 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 this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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Cold Sterilization Log

<u>Follow Manufacture's</u> recommended solution soaking time for sterilization, use of test strips to ensure solution efficiently destroys 100% of *Mycobacteriu Tuberculosis* and solution change.

Date	Name of Solution	Type of Instruments in Solution	Length of Time Items in Solution	Initials	Date Solution Tested	Solution Test Results	Date Solution Changed	Initials

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | **Age** | ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** *(mm/dd/yyyy)* | **Country of Birth**

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | **Date of First Specimen Collection** *(mm/dd/yyyy)* | **Date of Diagnosis** *(mm/dd/yyyy)* | **Date of Death** *(mm/dd/yyyy)*

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | **City** | **State** | **ZIP Code**

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis?
☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

Criteria for Hospice Appropriateness

General Criteria

- ✍ Patient's illness is incurable and has a declining functional status
- ✍ The patient/family have been informed that the patient's condition is terminal
- ✍ The patient/family have elected treatment directed toward palliative care
- ✍ Quality of life is currently unacceptable to the patient/family
- ✍ Prognosis is for a life expectancy of approximately 6 months or less (if the disease runs its normal course)

Observable clinical deterioration examples may include:

- ✍ Unintentional weight loss – more than 10% over last 3 - 6 months
- ✍ Decreased appetite/nutritional intake related to the terminal process
- ✍ Decreased activity tolerance with restriction in activities of daily living
- ✍ Decreased cognitive abilities
- ✍ Multiple emergency room visits (3 or more) in last 3 - 6 months

Disease Organ-Specific Examples

End-Stage Cardiopulmonary Disease:

- ✍ Disabling dyspnea at rest or with minimal exertion, poorly responsive to bronchodilators
- ✍ Recurrent congestive heart failure (NYHA Class IV) on optimal diuretic therapy
- ✍ Presence of corpulmonale
- ✍ Recurrent pulmonary infections and/or respiratory failure
- ✍ Chronic hypoxemia (less than 90%) at rest on supplemental oxygen
- ✍ Chronic hypercapnia (pCO2 more than 50 mm Hg)
- ✍ Intractable angina
- ✍ Resting tachycardia (more than100/min) or symptomatic arrhythmias resistant to therapy

End-Stage Neurologic Disease:

- ✍ Severe Alzheimer's, stroke, Parkinson's, ALS, traumatic brain injury

End-Stage Renal Disease

- ✍ Chronic dialysis patient/candidate who has chosen to refuse dialysis

End-Stage Liver Disease

- ✍ Severe Ascites, esophageal varices, peripheral edema, jaundice, hepatic encephalopathy/coma

End-Stage AIDS

- ✍ Severe weight loss, recurrent infections, increased debilitation requiring supportive care, has been on therapy and refusing therapy or has displayed resistance to available medications

Malignant Disease

- ✍ Documented tissue diagnosis of malignant/metastatic disease. Incurable diagnosis and treatment is regarded most likely to be futile
- ✍ Evidence of progressive cancer and treatment (even if available) is felt to be futile
- ✍ Patient with curable disease but treatment is refused or cannot be tolerated. Or where treatment is for palliative reasons

Decision Power®

Referral to Health Net Fax Form

- **California – HMO/Point-of-Service (POS)/HSP, EPO, PPO, Medicare Advantage (MA) HMO**

Decision Power® clinicians are available 24 hours a day, 365 days a year to provide education and support to eligible Health Net members who have chronic conditions. **To refer a patient to Health Net's Decision Power Disease Management or Wellness programs, please complete this form and fax it to Decision Power at 1-800-451-4730. Note: Do not mail this completed form; fax only please.**

Provider Information:

Name:	
Office telephone:	
Email address:	
Date of referral:	
Reason for referral:	

Member Information:

First and Last Name	Subscriber ID #	Gender	DOB	Telephone #	Program Referred For

Referrals are accepted for the following:

Targeted disease management conditions

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Heart Failure (HF)

Lifestyle programs

- Quit For Life™ (tobacco cessation)
- Wellness Health Coaching (weight loss, stress management, exercise and/or healthy eating)

Types of Support

- Adherence to treatment plan
- Gap closure
- High-risk chronic condition management
- Medication persistence
- Nutrition/lifestyle changes

Note: This form should not be used to refer Medi-Cal members.

****For case management needs, please refer to the Healthcare Services Department Case Management Referral Form, available in the Forms section of the Provider Library on the Health Net provider website at provider.healthnet.com, and fax to 1-800-745-6955.***

Enrollees have access to Decision Power through their current enrollment with any health plan offered by the following Health Net, LLC-affiliated companies: Health Net of California, Inc. and Health Net Life Insurance Company. Decision Power is not part of Health Net's medical benefit plans. Decision Power services, including clinicians are additional resources that Health Net makes available to enrollees. Decision Power is not affiliated with Health Net's provider network. Decision Power services are not subject to the Medicare appeals process. Disputes regarding products and services may be subject to Health Net's grievance process. Health Net, LLC may revise or withdraw the availability of Decision Power without notice. Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net and Decision Power are registered service marks of Health Net, LLC. All rights reserved.

Revised – July 2019

HNCA CODE LISTS - *By Modality and In Numerical Order*

COMPLETE CODE LIST

The Lists are in Numerical Order and divided by Modality below:

CT/CTA

CT - Computed Tomography

CTA - Computed Tomography Angiography

MRI/MRA

MRI - Magnetic Resonance Imaging

MRA - Magnetic Resonance Angiography

NOTE: NCM-MPI-MUGA included for HNCA HMO members starting 1-1-14

NCM – MPI – MUGA

Nuclear Cardiac Medicine (NCM)

Myocardial Perfusion Imaging(MPI)

MUGA, [aka: Blood Pool Imaging]

PET & PET/CT

PET and PET/CT - *Positron Emission Tomography*

3D RENDERING

SLEEP STUDIES

HNCA CODE LISTS - *By Modality and In Numerical Order*

CT - Computed Tomography			
0042T	Cerebral perfusion analysis using CT with contrast administration,		
70450	CT Head without contrast	**70460**	CT Head with contrast
70470	CT Head with & without contrast W & W/O		
70480	CT Orbit, sella, or posterior fossa or outer, middle, or inner ear W/O		
70481	CT Orbit, sella, or posterior fossa or outer, middle, or inner ear with contrast		
70482	CT Orbit, sella, or posterior fossa or outer, middle, or inner ear W & W/O		
70486	CT Maxillofacial area, (sinus) without contrast		
70487	CT Maxillofacial area, (sinus) with contrast		
70488	CT Maxillofacial area, (sinus) with & without contrast W & W/O		
70490	CT Soft-tissue Neck W/O	**70491**	CT Soft-tissue Neck with contrast
70492	CT Soft-tissue Neck with & without contrast W & W/O		
71250	CT Chest without contrast	**71260**	CT Chest with contrast
71270	CT Chest with and without contrast W & W/O		
72125	CT Cervical Spine W/O	**72126**	CT Cervical Spine with contrast
72127	CT Cervical Spine with and without contrast W & W/O		
72128	CT Thoracic Spine W/O	**72129**	CT Thoracic Spine with contrast
72130	CT Thoracic Spine with and without contrast W & W/O		
72131	CT Lumbar Spine W/O	**72132**	CT Lumbar Spine with contrast
72133	CT Lumbar Spine with and without out contrast W & W/O		
72192	CT Pelvis W/O	**72193**	CT Pelvis with contrast
72194	CT Pelvis with and without contrast W & W/O		
73200	CT Upper Extremity W/O	**73201**	CT Upper Extremity with contrast
73202	CT Upper Extremity with and without contrast W & W/O		
73700	CT Lower Extremity W/O	**73701**	CT Lower Extremity with contrast
73702	CT Lower Extremity with and without contrast W & W/O		
74150	CT Abdomen W/O	**74160**	CT Abdomen with contrast
74170	CT Abdomen with and without contrast W & W/O		
74176	CT ABDOMEN and PELVIS; without contrast		
74177	CT ABDOMEN and PELVIS; with contrast		
74178	CT ABDOMEN and PELVIS; with & without contrast		
74261	CT Colonography, diagnostic; without contrast material		
74262	CT Colonography, diagnostic; with contrast material		
74263	CT Colonography, screening, including image postprocessing		
75571	CT, HEART, without contrast with quantitative evaluation of coronary calcium		
75572	CT, heart, with contrast, for evaluation of cardiac structure and morphology		
75573	CT, heart, with contrast, for evaluation of cardiac structure and morphology in the setting of congenital heart disease		
75574	CT, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing		
76380	CT Limited or Localized follow-up		
76497	Unlisted CT procedure (e.g., diagnostic, interventional)		
77078	CT BONE MINERAL DENSITY study, 1 or more sites, axial skeleton		
S8092	CT ELECTRON BEAM (also known as Ultrafast CT, Cine CT)		

RETURN

HNCA CODE LISTS - *By Modality and In Numerical Order*

CTA - Computed Tomographic Angiography			
70496	CT Angiography (CTA), Head- includes post-processing		
70498	CT Angiography (CTA), Neck-includes post-processing		
71275	CT Angiography (CTA), Chest (NON-CORONARY) includes post-processing		
72191	CT Angiography (CTA) Pelvis-includes post-processing		
73206	CT Angiography (CTA) Upper Extremity-includes post-processing		
73706	CT Angiography (CTA) Lower Extremity- includes post-processing		
74174	CT Angiography (CTA) Abdomen and Pelvis- W & W/O includes post-processing		
74175	CT Angiography (CTA) Abdomen- W & W/O includes post-processing		
75635	CT Angiography (CTA) Abdominal Aorta and bilateral iliofemoral lower extremity runoff		
MRI – Magnetic Resonance Imaging			
0159T	CAD for BREAST MRI	**70336**	MRI Temporomandibular Joint(s) TMJ
70540	MRI Orbit, Face and/or Neck W/O	**70542**	MRI Orbit, Face and/or Neck with contrast
70543	MRI Orbit, Face and/or Neck with and without contrast W & W/O		
70551	MRI Brain (Head) W/O	**70552**	MRI Brain (Head) with contrast
70553	MRI Brain (Head) with and without contrast W & W/O		
70554	MRI Brain, **functional MRI**; not requiring physician or psychologist		
70555	MRI, Brain, **functional MRI;** requiring physician or psychologist		
71550	MRI Chest W/O	**71551**	MRI Chest with contrast
71552	MRI Chest with and without contrast W & W/O		
72141	MRI Cervical Spine W/O	**72142**	MRI Cervical Spine with contrast
72146	MRI Thoracic Spine W/O	**72147**	MRI Thoracic Spine with contrast
72148	MRI Lumbar Spine W/O	**72149**	MRI Lumbar Spine with contrast
72156	MRI Cervical Spine with and without contrast W & W/O		
72157	MRI Thoracic Spine with and without contrast W & W/O		
72158	MRI Lumbar Spine with and without contrast W & W/O		
72195	MRI Pelvis W/O	**72196**	MRI Pelvis with contrast
72197	MRI Pelvis with and without contrast W & W/O		
73218	MRI Upper Extremity-*other than joint*-without contrast		
73219	MRI Upper Extremity-*other than joint*-with contrast		
73220	MRI Upper Extremity-*other than joint*-with and without contrast W & W/O		
73221	MRI Any Joint Upper Extremity W/O	**73222**	MRI Any Joint Upper Extremity--with contrast
73223	MRI Any Joint of Upper Extremity—with and without contrast W & W/O		
73718	MRI Lower Extremity-*other than joint*-without contrast		
73719	MRI Lower Extremity-*other than joint*-with contrast		
73720	MRI Lower Extremity-*other than joint*-with and without contrast W & W/O		
73721	MRI Any Joint of Lower Extremity W/O	**73722**	MRI Any Joint of Lower Extremity--with
73723	MRI Any Joint of Lower Extremity—with and without contrast W & W/O		
74181	MRI Abdomen W/O	**74182**	MRI Abdomen with contrast
74183	MRI Abdomen with and without contrast W & W/O		
75557	Cardiac MRI for morphology and function without contrast materials		
75559	Cardiac MRI for morphology and function without contrast materials; with stress imaging		
75561	Cardiac MRI for morphology and function WO, followed by contrast		
75563	Cardiac MRI for morphology and function WO, followed by contrast; with stress imaging		
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately)		
76390	MR Spectroscopy (MRS)		
76498	Unlisted MR procedure (eg, diagnostic, interventional)		
77058	MRI BREAST, UNILATERAL	**77059**	MRI BREAST, BILATERAL

RETURN

HNCA CODE LISTS - *By Modality and In Numerical Order*

MRI – Magnetic Resonance Imaging	
77084	MRI Bone Marrow blood supply
S8035	Magnetic source imaging
S8037	MRCP (Magnetic Resonance Cholangiopancreatography)
S8042	MRI Low-Field

MRA – Magnetic Resonance Angiography			
70544	MRA Head without contrast	**70545**	MRA Head with contrast
70546	MR Angiography (MRA) Head with and without contrast W & W/O		
70547	MRA Neck without contrast	**70548**	MRA Neck with contrast
70549	MR Angiography (MRA) Neck with and without contrast W & W/O		
71555	MR Angiography (MRA) Chest (excluding myocardium)- W or W/O		
72159	MR Angiography (MRA) Spinal Canal and contents		
72198	MR Angiography (MRA) Pelvis -with or without contrast		
73225	MR Angiography (MRA) Upper Extremity -with or without contrast		
73725	MR Angiography (MRA) Lower Extremity-with or without contrast		
74185	MR Angiography (MRA) Abdomen-with or without contrast		

MPI – *Myocardial Perfusion Imaging* NCM – *Nuclear Cardiac Imaging*	
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative **wall motion**, **ejection fraction** by first pass or gated technique, additional quantification, when performed); **single study, at rest or stress**
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative **wall motion**, **ejection fraction** by first pass or gated technique, additional quantification, when performed); **multiple studies, at rest and/or stress**
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); **single study, at rest or stress**
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); **multiple studies, at rest and/or stress**
78466	Myocardial Imaging, infarct avid, planar; qualitative or quantitative
78468	Myocardial Imaging, infarct avid, planar; w/ EF by first pass technique
78469	Myocardial Imaging, infarct avid, planar; tomographic SPECT
78472	Cardiac Blood Pool imaging, gated equilibrium; planar, single study at rest **or** stress
78473	Cardiac Blood Pool imaging, multiple studies, at rest **and** stress,
78481	Cardiac Blood Pool imaging, (planar), first pass technique; single study, at rest or with stress
78483	Cardiac Blood Pool imaging, (planar), first pass technique; multiple studies at rest and stress
78494	Cardiac Blood Pool imaging, gated equilibrium, SPECT
78496	Cardiac Blood Pool imaging, gated equilibrium, RV EF by first pass
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine

RETURN

HNCA CODE LISTS - *By Modality and In Numerical Order*

PET and PET/CT - Positron Emission Tomography			
78608	PET Brain – metabolic evaluation	**78609**	PET Brain – perfusion evaluation
78459	PET Cardiac–metabolic evaluation	**78491**	PET Cardiac–perfusion, single, rest or stress
78492	PET Cardiac (myocardial imaging), perfusion multiple studies rest/stress		
78811	PET Imaging; limited area (ex: chest, head/neck)		
78812	PET Imaging; skull base to mid-thigh	**78813**	PET Imaging; whole body
78814	PET/CT; limited area (ex: chest, head/neck)		
78815	PET/CT; skull base to mid-thigh	**78816**	PET/CT; whole body

3D RENDERING	
76376	3D rendering- ***not*** *requiring an independent workstation*
76377	3D rendering- *requiring an independent* workstation

SLEEP STUDIES	
95800	Sleep study with recording, unattended
95801	Sleep study with recording, unattended
95805	Sleep Study, multiple trials
95806	Sleep study with recording, unattended
95807	Sleep study with recording, attended by a technologist.
95808	Polysomnography* (Type I); 1-3 additional parameters
95810	Polysomnography* (Type I); 4 or more parameters
95811	Polysomnography* (Type I); 4 or more parameters with airway therapy ventilation
95782	Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783	Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
G0398	Home sleep study test Type II
G0399	Home sleep study test Type III
G0400	Home sleep study test Type IV

RETURN

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ **Prime** ☐ **Subawardee** Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount,** *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
Ankle-foot/knee-ankle-foot orthotics	Orthotic replacements are included in the reimbursement for orthotics
Automatic external defibrillators	External defibrillators are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*
Blood glucose monitoring	Glucose monitors/supplies are reimbursable for diabetics only and when reported with the appropriate modifier (KS or KX)
	Continuous noninvasive glucose monitors are considered experimental/investigational because the safety or efficacy of these devices have not been established by review of the available published literature
	A disposable glucose monitor is a non-covered item
Breast prosthesis	A custom breast prosthesis is reimbursed at the rate of a prefabricated breast prosthesis
Canes and crutches	When an underarm, articulating, spring-assisted crutch is provided, it is reimbursed at the rate of an underarm crutch other than wood
	Only one crutch type is covered per date of service
Cervical traction devices	Cervical traction that is free-standing or attached to a headboard is reimbursed at the rate of overdoor cervical traction
	Free-standing cervical traction is eligible for reimbursement coverage when requirements have been met and filed with the appropriate modifier.* Otherwise it is reimbursed at the rate for overdoor cervical traction
Cold therapy	A water circulating cold pad with pump is not eligible for reimbursement because it is considered investigational
Commodes	An extra wide/heavy duty commode chair is reimbursable for a member who weighs 300 pounds or more, when reported with the appropriate modifier.* It is otherwise reimbursable at the rate for a regular commode if basic coverage criteria for a commode chair are met
	A commode chair with detachable arms is reimbursable when the clinical criteria are met and when it is reported with the appropriate modifier*
	A pail or pan for use with commode chair is included in the reimbursement for a commode chair
	A seat-lift mechanism is included in the reimbursement for a commode chair with a seat-lift mechanism

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
Diabetic shoes	Orthopedic shoes and accessories for members with diabetes are reimbursable when reported with codes specific to diabetic footwear
	An insert that is direct formed and molded to a member's foot without an external heat source is a non-covered item
Enteral nutrition	Enteral feeding supply kits are reimbursable once per day
	Additives for enteral formula are included in the reimbursement for enteral formulas
	Components of a more complete kit are included in the reimbursement for the kit
External infusion pumps	Supplies for maintaining a drug infusion catheter are not eligible for reimbursement in the same month as a drug infusion kit
	Components of a more complete kit are included in the reimbursement for the kit
	IV poles are included in the reimbursement of ambulatory infusion pumps
	Replacement batteries for an infusion pump are included in the monthly rental reimbursement of an infusion pump
Hospital headboards and accessories	Hospital bed rental is reimbursable once per month
	Hospital bed accessories that are part of the more complete hospital bed are included in the reimbursement for the hospital bed
	Hospital bed rails are included in the reimbursement for hospital beds with bed rails
	Hospital bed rails and mattresses are included in the reimbursement for hospital beds with bed rails and mattresses in their description
Intrapulmonary percussive ventilation (IPV) systems	Intrapulmonary percussive ventilation systems are not covered in the home, assisted living, group home, or custodial care setting
Lower limb prosthesis	A below-knee suction socket or suction suspension for an above-knee or knee disarticulation socket is not separately reimbursed with a knee suspension locking mechanism
	A custom fabricated socket insert is not eligible for reimbursement when reported with a replacement prosthesis or addition
	Lower extremity diagnostic test sockets are included in reimbursement for immediate prosthesis
	A maximum of two test (diagnostic) sockets for an individual prosthesis is considered for reimbursement.
	Special features for lower limb prosthesis (such as multiaxial ankle/foot, flexfoot system, high activity knee) is considered for reimbursement based on the member's functional level
	Special features/additions added at the time of provision of the preparatory prosthesis are not separately reimbursed

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
	Replacement prosthesis components are not reimbursable when reported with a prosthesis
Manual and power wheelchair accessories	Manual wheelchair accessories are appropriately reported when used with manual wheelchairs
	Power wheelchair accessories are appropriately reported when used with power wheelchairs
Modifiers	Prosthetics and orthotics that can be reported bilaterally require an RT (right) and/or LT (left) modifier
	Lower limb prostheses require a valid and appropriate functional modifier (K0-K4)
	A prosthesis is reimbursable when there is expectation that the amputee reaches or maintains a defined functional state within a reasonable time frame and when reported with the appropriate modifier
	Capped rental modifiers are restricted to usage with items listed as capped rental equipment by the Centers for Medicare and Medicaid Services (CMS)
	Items requiring an order prior to delivery (pressure reducing surfaces, power operated vehicles, seat lift mechanisms, or TENS units) are reimbursable when a written order is on file prior to delivery. In this case, report the code with modifier EY
	For DMEPOS providers, adhesive tape requires an appropriate modifier (AU, AV, AW or AX.). Adhesive tape is not reimbursable in an office setting
Nebulizers	Disposable large volume nebulizers are non-covered items
	Controlled inhalation medication delivery system is eligible for reimbursement when reported with the appropriate medication
	A pharmacy supply fee is reimbursable when reported with the appropriate medications
	A 90-day dispensing fee is reimbursable once per 90 days
	A 30-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 90-day pharmacy dispensing fee
	A 90-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 30-day pharmacy dispensing fee
	A 30-day pharmacy dispensing fee for inhalation medication(s) is reimbursable once per month
Non-contact normothermic wound warming devices	The non-contact wound warming device and accessories are not eligible for reimbursement as they are not considered safe nor effective
Osteogenesis stimulators	Only one type of osteogenesis (bone) stimulator is reimbursable for covered fractures
Ostomy supplies	Components of a more complete kit are included in the reimbursement for the kit

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
	Options and accessories that are part of a more complete ostomy product are included in the reimbursement for the ostomy appliance
Oxygen and oxygen equipment	Only one oxygen stationary system rental is reimbursable per month for those who qualify for coverage
	Portable oxygen rental is reimbursable once per month
	Frequently serviced items, such as oxygen systems, are reimbursable as a rental only
	Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement
	Oxygen contents reimbursement is included in the reimbursement for monthly rental of a stationary oxygen system
	Oxygen modifiers QE, QF and QG are recognized only when submitted with stationary oxygen rentals
	Oxygen is included in monthly oxygen system rental
Parenteral nutrition	Parental nutrition administration pumps are reimbursable once per month
	Homemix nutrient and component solutions are included in the reimbursement for the complete premix solution
	Parenteral nutrients solution is reimbursable at one unit per day
	One supply kit and one administration kit are reimbursable for each day that parenteral nutrition is administered
	Use of an IV pole and parenteral nutrition pump in an outpatient setting is included in the reimbursement for the underlying nutrition service
Patient lifts	An electric patient lift with seat and a multi-positional patient support system with integrated lift are non-covered items
	Patient lifts for the toilet and patient lifts that are free moving or fixed are non-covered items
	A sling is included in the reimbursement for a patient lift
Pneumatic compression devices	A segmental pneumatic appliance is eligible for reimbursement when reported with a segmental pneumatic compressor
	A non-segmental pneumatic compression appliance or segmental gradient pressure pneumatic appliance is eligible for reimbursement when reported with a non-segmental pneumatic compressor
Pressure reducing support surfaces	Alternating pressure pad and pressure pad alternating pump replacement are included in the reimbursement for an alternating pressure pad with pump
Prosthetic repair and replacement	Labor is included in the reimbursement for the replacement prosthesis and components
	Labor for prosthetic repair is included in the reimbursement for the prosthesis when it is reported within 90 days of a prosthesis

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
Rentals	Rental durable medical equipment (DME) is considered for reimbursement once per month
	Capped rental equipment is reimbursable for a total of 13 months
	Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months
Repair	Repair of DME is included in the initial provision of DME
Transcutaneous electrical nerver stimulations (TENS)	The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee
Urological Supplies	A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device
	Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period
	Sterile intermittent catheters are reimbursable up to 600 times within 90 days
Walkers	Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement
Wheelchair options and accessories	Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option

*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record

The following claims coding edits apply to Health Net claims for the Medicare Advantage (MA) line of business:

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	
Category	**Coding Edit**
Blood glucose monitoring	Only one home blood glucose monitor is reimbursable per 12-month period of time
	A laser skin piercing device or replacement cartridge is reimbursed at the rate for the spring powered lancet and/or lancet replacements
	Urine test reagent strips, alcohol, peroxide, Betadine, and pHisohex are not separately reimbursed with glucose monitors and supplies
Diabetic shoes	Only one pair of therapeutic shoes for members with diabetes is reimbursable per calendar year
	Therapeutic shoe inserts or modifications for members with diabetes are reimbursable up to six units per calendar year
	Diabetic shoe inserts or modifications reported with non-diabetic footwear are not eligible for reimbursement
Enteral nutrition	Nasogastric tubes are reimbursable once a month
Eye prosthesis	An eye prosthesis is eligible for replacement once the useful lifetime of the prosthesis is reached (typically five years)
Lower limb prosthesis	Two test sockets are reimbursable per individual prosthesis
Nebulizers	Corrugated tubing for use with a large volume nebulizer is reimbursable once per two months
	An immersion heater for a nebulizer or durable bottle type nebulizer is reimbursable once per three years
	A non-disposable administration set used with a small volume nebulizer reimbursable once every six months
	The non-disposable administration set is reimbursable once every three months if used with a controlled dose inhalation delivery system
	Atropine, administered by nebulizer, is reimbursable up to 558 units every 3 months
	Bitolterol, administered by nebulizer, is reimbursable up to 1302 units every 3 months
	Glycopyrrolate, administered by nebulizer, is reimbursable up to 225 units every 3 months
	Isoetharine HCL, administered by nebulizer, is reimbursable up to 2790 units every 3 months
	Metaproteranol sulfate, administered by nebulizer, is reimbursable up to 740 units every 3 months
	Terbutaline sulfate, administered by nebulizer, is reimbursable up to 558 units every 3 months
	Isoproterenol HCL, administered by nebulizer, is reimbursable up to 1350 units every 3 months
Orthopedic footwear	Orthopedic footwear and the associated inserts or modifications are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*
	Custom-molded prosthetic shoes are not reimbursable when reported with partial foot prosthesis or other lower extremity prosthesis
Oxygen and oxygen	Oximeters and replacement probes are not covered because they do not meet the definition of DME

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	
Category	**Coding Edit**
equipment	Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement
	Oxygen is included in monthly oxygen system rental
Pneumatic compression devices	Only one type of pneumatic compressor (lymphedema pump) is eligible for reimbursement in the same month
Rental	Capped rental equipment is reimbursable for a total of 13 months
	Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months
Replacement	Durable medical equipment is eligible for replacement after its useful lifetime has been reached (typically a period of 5 years).
Transcutaneous electrical nerver stimulations (TENS)	The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee
Urological supplies	Urinary catheter insertion trays are considered for reimbursement at the frequency of two per calendar month. An additional two foley catheters are considered for reimbursement in the same month
	Bedside urinary drainage bags are eligible for reimbursement at the frequency of two per month
	Adhesive tape used with ostomy or urological supplies is eligible for reimbursement up to 40 units per month
	A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device
	Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period
	Sterile intermittent catheters are reimbursable up to 600 times within 90 days
Walkers	When an enclosed walker with rear seat is provided, it is reimbursed at the rate of a standard walker
	Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement
Wheelchair options and accessories	Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option

*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record.

All claims submissions remain subject to Health Net's prior authorization requirements.

Health Net does not require documentation at the time of claim submission. In the event the claim is audited, documentation may be required.

Supporting Sources:

- DME MAC
- HCPCS Level II
- Medicare National Coverage Determinations Manual (NCD)

ELIGIBILITY REPORT FIELD DESCRIPTIONS

Field	Description
Header Information	
Report BRM42	A Health Net-assigned number for the Eligibility Report
Report Title	The name of the report
Date	The day/month/year that the report was system generated
Page Number	The page number of the report
Provider ID	Three- or Four-digit number Health Net assigns to each PPG
Provider Name	Name of the PPG
Provider Address	Address of the provider.
Provider Phone Number	Phone Number of the provider.
Report Information	
Member Name	First, last and middle initial of the member
Member Sex Code	A single-digit code indicating the gender of the subscriber: • M= male • F= female
Member ID	Reports for commercial providers will have subscriber's ID/Ref ID number as shown on the Health Net ID card (usually the subscriber's Social Security number) Reports for medi-cal providers will have CIN Number(subscriber's client identification number)replaced for subscriber's ID/Ref ID
CMS HIC #	The identification number assigned to the member by the Centers for Medicare and Medicaid Services (CMS)
Group ID #	A eight-position code assigned to each employer group
Product code	A 3 or 4 position code that identifies the product type. Example, MDE, MLA, MCR, SDE, INDV
Plan Code	A three-character code that identifies the medical plan of the employer group assigned by Health Net. Example, BS5, BRZ, AMT, BS1
IN	A one-position code that identifies if a member has mental health benefits through an outside provider, for example, INSIGHT
RX	A one-position code that identifies if a member has pharmacy benefits as an optional benefit
Medi-Medi	A one-position flag which indicates if • Y - Dual Coverage (Both Medicare & Medical) • N – Only one Coverage (Medicare or Medical)
PR TY	A one-position code that identifies the product type of the member's employer group: • M = Standard HMO • P = POS HMO
Member Status	0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized, 4 = Working Aged
MHN	A one-position flag which indicate if member has MHN(Mental Health Net)

Field	Description
CHI	A one-position flag which indicate if member has CHI(Chiro)
TPT	A one-position flag which indicate if member has TPT(Transportation)
Benefit/Copayment information	Office Visits(o/v) – benefit or copayment amount for office visits: DME - benefit or copayment amount for durable medical equipment ER - benefit or copayment amount for Emergency Room Yes – member is fully covered with no copayment required No – member is not covered for benefits at all $/% - copayment indicated by dollar amount or percentage
COB ID	The Health Net COB carrier's ID for the member. This information may not always be current
Date of Birth	The member's date of birth
Physician ID	The assigned physician ID code used for site reports
Provider ID	The name of the PPG and the three- or four-digit number Health Net assigns to each PPG
Provider Effective Date	The date the member became eligible to use the PPG
Provider Cancel Date	The last day the member is eligible to receive services at the PPG
Funding Type	A one-position funding description for the corresponding product type: R = Regular funding F = Flex funding S = Self funding
CIN#	A 9 character number for Cin Number
Aid code	A two-position code(either two numbers or a number and a letter), which assist providers in identifying the types of services for which Medi-Cal recipients are eligible.
Project code	A 3-position code which identifies the project code of a member.
Medicare part A flag	A one-position flag which indicate if member has Part A coverage(Hospital insurance)
Medicare part B flag	A one-position flag which indicate if member has Part B coverage(Medical insurance)
Medicare part D flag	A one-position flag which indicate if member has Part D coverage(outpatient Prescription Drug insurance)
Aid category Description	A 15 position description that identifies the aid category in which the member belongs.
Dialysis Indicator	A one-position flag which indicate if member has dialysis
Address	The member's home address, city, state, zip & phone number.
Race Ethnicity	A 12 position code which indicates member spoken language, written language, race & ethnicity.
Coordination of Benefits (COB) Table	A summary of applicable COB carriers. This information is provided only if it is available on file
Totals	
Members eligible at month end	A summary of members who are eligible at month end according to product type
Total Members eligible at	A total summary of members who are eligible at month end for

Field	Description
month end	all product type

Eligibility Summary By Group File

Eligibility Summary by Group File			
Field Name	**Position**	**Format**	**Description**
Header Record			
Record Type	001-001	X(1)	"1" = Header Record
Title	002-009	X(8)	"PGRP HDR"
Information effective date	010-017	X(8)	CCYYMMDD, Effective Date
Provider type	018-018	X(1)	"M" = Medical provider "H" = Hospital provider
Provider ID	019-022	X(4)	PPG or hospital number
Provider name	023-055	X(33)	PPG or hospital name
Address	056-080	X(25)	PPG or hospital address
City	081-097	X(17)	PPG or hospital city
State	098-099	X(2)	PPG or hospital state
Zip Code	100-108	X(9)	PPG or hospital zip code
Provider Phone Number	109-118	X(10)	PPG or hospital phone number
Provider Phone Number Ext.	119-122	X(4)	PPG or hospital phone number extension
Filler	123-142	X(20)	Blank
Detail Record			
Record Type	001-001	X(1)	"2" Detail Record
Group Name	002-051	X(50)	Health Net employer/individual group name
Group ID	052-059	X(8)	Health Net employer/individual group number
Plan Code	060-063	X(4)	Medical plan of the employer/individual group the member belongs to
Filler	064-065	X(2)	Blank
Filler	066-073	X(8)	Blank
Filler	074-081	X(8)	Blank

Eligibility Summary by Group File			
Filler	082-089	X(8)	Blank
Members	090-097	9(8)	Number of members per employer/individual group eligible for this provider/hospital
PR TY	098-098	X(1)	Product Type - "M" = Medicare, "P" = Medicare POS
Supplemental Codes	099-126	X(28)	Total number of members
Filler	127-142	X(16)	Blank
Trailer Record			
Record Type	001-001	X(1)	"3" = Trailer Record
Title	002-009	X(8)	"PGRP SUM"
Total Members	010-017	9(8)	Group supplemental benefit codes
Total Records	018-025	9(8)	Total number of records processed
Filler	026-142	X(117)	Blanks

HEALTH NET MEDICARE ADVANTAGE
ELIGIBILITY SUMMARY BY GROUP AND PROVIDER REPORT FIELD DESCRIPTIONS

Field	Description
Header Information	
Report BRM 42	A Health Net-assigned number for the Eligibility Summary by Group Report
Report Title	The name of the report
Date	The day/month/year that the report was system generated
Page Number	The page number of the report
Report Information	
Provider ID	The name of the PPG and the three- or four-digit number Health Net assigns to each PPG
Group ID	A six-position code assigned to each employer group
PR TY	A single-letter code that identifies the product type of the member's employer group: • M = Standard HMO • N = POS HMO
Plan Code	A two-position code that identifies the type of benefits chosen by the employer group
Supplemental Benefits	Codes that denote if the member's employer group purchased supplemental benefits for their employees
Elig Mbrs	The number of eligible members for that specific employer group
SPC members eligible within provider as of month end	The number of eligible members by product type
Total members eligible as of month end	The grand total number of members as of month end

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	X	
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	X	
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	X	
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)		X
31238	Nasal/sinus endoscopy, surgical; with control of hemorrhage		X
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy		X
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection		X
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery		X
31253	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed		X
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)		X
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior		X
31256	Nasal/sinus endoscopy, surgical; with maxillary antrostomy		X
31257	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior), including sphenoidotomy		X
31259	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus		X
31267	Nasal/sinus endoscopy, surgical; with removal of tissue from maxillary sinus		X
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus		X
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy		X
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from sphenoid sinus		X
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region		X
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region		X
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression		X
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression		X
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression		X
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium, transnasal or via canine fossa		X
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium		X
31297	Nasal/sinus endoscopy, surgical; with dilation of spenoid sinus ostium		X
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal sphenoid sinus osia (such as balloon dilation)		X
31505	Laryngoscopy, indirect; diagnostic (separate procedure)	X	
31510	Laryngoscopy, indirect; with biopsy	X	
31511	Laryngoscopy, indirect; with removal of foreign body		X
31512	Laryngoscopy, indirect; with removal of lesion		X
31513	Laryngoscopy, indirect; with vocal cord injection		X
31515	Laryngoscopy, direct, with or without tracheoscopy; for aspiration		X
31520	Laryngoscopy, direct, with or without tracheoscopy; diagnostic, newborn	X	
31525	Laryngoscopy, direct, with or without tracheoscopy; diagnostic, except newborn	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
31526	Laryngoscopy, direct, with or without tracheoscopy; diagnostic, with operating microscope	X	
31527	Laryngoscopy, direct, with or without tracheoscopy; with insertion of obturator		X
31528	Laryngoscopy, direct, with or without tracheoscopy; with dilation, initial		X
31529	Laryngoscopy, direct, with or without tracheoscopy; with dilation, subsequent		X
31530	Laryngoscopy, direct, operative with foreign body removal		X
31531	Laryngoscopy, direct, operative with foreign body removal; with operating microscope		X
31535	Laryngoscopy, direct, operative, with biopsy		X
31536	Laryngoscopy, direct, operative, with biopsy; with operating microscope		X
31540	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis		X
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope		X
31545	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)		X
31546	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (includes obtaining autograft)		X
31560	Laryngoscopy, direct, operative, with arythenoidectomy		X
31561	Laryngoscopy, direct, operative, with arythenoidectomy; with operating microscope		X
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic		X
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope		X
31572	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral		X
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral		X
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral		X
31575	Laryngoscopy, flexible fiberoptic; diagnostic	X	
31576	Laryngoscopy, flexible fiberoptic; with biopsy	X	
31577	Laryngoscopy, flexible fiberoptic; with removal of foreign body		X
31578	Laryngoscopy, flexible fiberoptic; with removal of lesion		X
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy		X
31615	Tracheobronchoscopy through established tracheostomy incision		X
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, diagnostic, with cell washing when performed (separate procedure)	X	
31623	Bronchoscopy, rigid or flexible, with brushing or protected brushings	X	
31624	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage	X	
31625	Bronchoscopy, rigid or flexible, with bronchial or endobronchial biopsy(s), single or multiple sites	X	
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, diagnostic, with placement of fiduciary markers, single or multiple		X
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, diagnostic, with computer assisted image guided navigation (List separately in addition to code for primary procedure)	X	
31628	Bronchoscopy, rigid or flexible with transbronchial lung biopsy(s) single lobe	X	
31629	Bronchoscopy, rigid or flexible, with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
31630	Bronchoscopy, rigid or flexible, with tracheal/ bronchial dilation or closed reduction of fracture		X
31631	Bronchoscopy, rigid or flexible with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)		X
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	X	
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	X	
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (for example fibrin glue), if performed procedure)		X
31635	Bronchoscopy, rigid or flexible, with removal of foreign body		X
31636	Bronchoscopy, rigid or flexible, with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus		X
31637	Bronchoscopy, rigid or flexible, each additional major bronchus stented (list separately in addition to code for primary procedure)		X
31638	Bronchoscopy, rigid or flexible, with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)		X
31640	Bronchoscopy, rigid or flexible, with excision of tumor		X
31641	Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (for example laser therapy, cryotherapy)		X
31643	Bronchoscopy, (rigid or flexible); with placement of catheter (s) for intracavitary radioelement application		X
31645	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of thracheobronchial tree, initial (for example, drainage of lung abscess)		X
31646	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent		X
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe		X
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe		X
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)		X
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])		X
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	X	
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g.,	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
	aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures		
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (list separately in addition to code for primary procedure[s])	X	
32601	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy	X	
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy	X	
32606	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy	X	
32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (for example wedge, incisional), unilateral		X
32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (for example wedge, incisional), unilateral		X
32609	Thoracoscopy; with biopsy(ies) of pleura		X
32650	Thoracoscopy, surgical; with pleurodesis (for example, mechanical or chemical) any method		X
32651	Thoracoscopy, surgical; with partial pulmonary decortication		X
32652	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis		X
32653	Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit		X
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage		X
32655	Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure		X
32656	Thoracoscopy, surgical; with parietal pleurectomy		X
32658	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac		X
32659	Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage		X
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass		X
32662	Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass		X
32663	Thoracoscopy, surgical; with lobectomy, total or segmental		X
32664	Thoracoscopy, surgical; with thoracic sympathectomy		X
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)		X
32666	Thoracoscopy, surgical; with therapeutic wedge resection (for example mass, nodule), initial unilateral		X
32667	Thoracoscopy, surgical; with therapeutic wedge resection (for example mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)		X
32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)		X
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)		X
32670	Thoracoscopy, surgical; with removal of 2 lobes (bilobectomy)		X
32671	Thoracoscopy, surgical; with removal of lung (pneumonectomy)		X
32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed		X
32673	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
32674	Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)		X
39401	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (e.g., lymphoma), when performed	X	
39402	Mediastinoscopy; with lymph node biopsy(ies) (e.g., lung cancer staging)	X	
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (for example Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed		X
43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	X	
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance		X
43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	X	
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)		X
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)		X
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire		X
43197	Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	X	
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple	X	
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	X	
43201	Esophagoscopy, flexible, transoral diagnostic, with directed submucosal injection(s), any substance		X
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	X	
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices		X
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices		X
43206	Esophagoscopy, flexible, transoral with optical endomicroscopy	X	
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed		X
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection		X
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)		X
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)		X
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)		X
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)		X
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesions(s) by hot biopsy forceps		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		X
43220	Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)		X
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilator(s) over guide wire		X
43227	Esophagoscopy, flexible, transoral; with control of bleeding any method		X
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination	X	
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	X	
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)		X
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
43236	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with directed submucosal injection(s), any substance		X
43237	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with endoscopic ultrasound examination limited to the esophagus	X	
43238	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)	X	
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	X	
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)		X
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter		X
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	X	
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices		X
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices		X
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (for example balloon, bougie)		X
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube		X
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)		X
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire		X
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps		X
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		X
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	X	
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (for example anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)		X
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection		X
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method		X
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease		X
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis	X	
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing (separate procedures)	X	
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	X	
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy		X
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)		X
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts		X
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method		X
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)		X
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	X	
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent		X
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)		X
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct		X
43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed		X
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed		X
43285	Removal of esophageal sphincter augmentation device		X
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon		X
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)		X
44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedures	X	
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	X	
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body		X
44364	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique		X
44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery		X
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X
44369	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique		X
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)		X
44372	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube		X
44373	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunosotomy tube		X
44376	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	X	
44377	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	X	
44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding, (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
44380	Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed(separate procedure)	X	
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation		X
44382	Ileoscopy, through stoma; with biopsy, single or multiple	X	
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre and post-dilation and guide wire passage, when performed)		X
44385	Endoscopic evaluation of small intestinal pouch (for example Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
44386	Endoscopic evaluation of small intestinal pouch (for example Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	X	
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
44389	Colonoscopy through stoma; with biopsy, single or multiple	X	
44390	Colonoscopy through stoma; with removal of foreign body(s)		X
44391	Colonoscopy through stoma; with control of bleeding, any method		X
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps		X
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		X
44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)		X
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)		X
44403	Colonoscopy through stoma; with endoscopic mucosal resection		X
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance		X
44405	Colonoscopy through stoma; with transendoscopic balloon dilation		X
44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	X	
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	X	
44408	Colonoscopy through stoma; with decompression (for pathologic distention) (for example volvulus, megacolon), including placement of decompression tube, when performed		X
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	X	
45303	Proctosigmoidoscopy, rigid; with dilation, (for example, balloon, guide wire, bougie)		X
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	X	
45307	Proctosigmoidoscopy, rigid; with removal of foreign body		X
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp or other lesion by hot biopsy forceps or bipolar cautery		X
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp or other lesion by snare technique		X
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps or other lesions by hot biopsy forceps, bipolar cautery or snare technique		X
45317	Proctosigmoidoscopy, rigid; with control of bleeding, (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
45320	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (for example, laser)		X
45321	Proctosigmoidoscopy, rigid; with decompression of volvulus		X
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)		X
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	X	
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)		X
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps		X
45334	Sigmoidoscopy, flexible; with control of bleeding, any method		X
45335	Sigmoidoscopy, flexible; with direct submucosal injection(s), any substance		X
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (for example volvulus, megacolon),including placement of decompression tube, when performed		X
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique		X
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation		X
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	X	
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	X	
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)		X
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection		X
45350	Sigmoidoscopy, flexible; with band ligation(s) (for example hemorrhoids)		X
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
45379	Colonoscopy, flexible, with removal of foreign body(s)		X
45380	Colonoscopy, flexible, with biopsy, single or multiple	X	
45381	Colonoscopy, flexible, with directed submucosal injection(s), any substance		X
45382	Colonoscopy, flexible, with control of bleeding, any method		X
45384	Colonoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps		X
45385	Colonoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique		X
45386	Colonoscopy, flexible, with transendoscopic balloon dilation		X
45388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)		X
45390	Colonoscopy, flexible; with endoscopic mucosal resection		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
45391	Colonoscopy, flexible, with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures.	X	
45392	Colonoscopy, flexible, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures.	X	
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (for example volvulus, megacolon), including placement of decompression tube, when performed		X
45398	Colonoscopy, flexible; with band ligation(s) (for example hemorrhoids)		X
46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (for example colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	X	
46604	Anoscopy; with dilation, (for example, balloon, guide wire, bougie)		X
46606	Anoscopy; with biopsy, single or multiple	X	
46607	Anoscopy; with high-resolution magnification (HRA) (for example colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	X	
46608	Anoscopy; with removal of foreign body		X
46610	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery		X
46611	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique		X
46612	Anoscopy; with removal of multiple tumors, polyps or other lesions by hot biopsy forceps, bipolar cautery or snare technique		X
46614	Anoscopy; with control of bleeding (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X
46615	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique		X
47550	Biliary endoscopy, intraoperative (choledochoscopy) (list separately in addition to code for primary procedure)	X	
47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing (separate procedure)	X	
47553	Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple	X	
47554	Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi		X
47555	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent		X
47556	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent		X
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	X	
49321	Laparoscopy, surgical; with biopsy (single or multiple)	X	
49322	Laparoscopy, surgical; with aspiration of cavity or cyst (for example, ovarian cyst) (single or multiple)		X
49323	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity		X
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (for example fiducial markers, dosimeter),		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
	intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)		
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum		X
50551	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service		X
50553	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography; with ureteral catheterization, with or without dilation of ureter		X
50555	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography; with biopsy		X
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
50562	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with resection of tumor		X
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service		X
50572	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter		X
50574	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with biopsy		X
50575	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)		X
50576	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
50945	Laparoscopy, surgical; ureterolithotomy		X
50947	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement		X
50948	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement		X
50949	Unlisted laparoscopy procedure, ureter		X
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service		X
50953	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter		X
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with biopsy		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
50970	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service		X
50972	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter		X
50974	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with biopsy	X	
50976	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50980	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
52000	Cystourethroscopy (separate procedure)	X	
52001	Cystourethroscopy with irrigation and evacuation of multiple obstructing clots		X
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service		X
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	X	
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation or duct radiology, exclusive of radiologic service		X
52204	Cystourethroscopy, with biopsy	X	
52250	Cystourethroscopy and radiotracer with or without biopsy or fulguration		X
52282	Cystourethroscopy, with insertion of urethral stent		X
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material		X
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus		X
52351	Cystourethroscopy with ureteroscopy and/or pyeloscopy; diagnostic	X	
52352	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)		X
52353	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)		X
52354	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of lesion		X
52355	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor		X
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (for example Gibbons or double-J type)		X
52400	Cystourethroscopy with incision, fulguration or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds		X
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts		X
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure		X
54690	Laparoscopy, surgical; orchiectomy		X
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis		X
57452	Colposcopy of the cervix including upper/adjacent vagina	X	
57454	Colposcopy of the cervix including upper/adjacent vagina;with biopsy(s) of the cervix and endocervical curettage		X
57455	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix	X	
57456	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage		X
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix	X	
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix		X
58555	Hysteroscopy, diagnostic (separate procedure)		X
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C		X
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)		X
58560	Hysteroscopy, surgical; with division of resection of intrauterine septum (any method)		X
58561	Hysteroscopy, surgical; with removal of leiomyomata		X
58562	Hysteroscopy, surgical; with removal of impacted foreign body		X
58563	Hysteroscopy, surgical; with endometrial ablation (for example endometrial resection, electrosurgical ablation, thermoablation)		X
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants		X
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)		X
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)		X
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera or peritoneal surface by any method		X
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal		X
G0104	Colorectal cancer screening; flexible sigmoidoscopy	X	
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	X	
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	X	
S0601	Screening proctoscopy	X	
C7509	Bronchoscopy, rigid or flexible, diagnostic with cell washing(s) when performed, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed	X	
C7510	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage(s), with computer-assisted image-guided navigation, including fluoroscopic guidance when performed		X
C7511	Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed	X	
C7512	Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with transendoscopic endobronchial ultrasound (EBUS) during	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
	bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance when performed		
C7541	Diagnostic endoscopic retrograde cholangiopancreatography (ERCP), including collection of specimen(s) by brushing or washing, when performed, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	X	
C7542	Endoscopic retrograde cholangiopancreatography (ERCP) with biopsy, single or multiple, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	X	
C7543	Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy/papillotomy, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)		X
C7544	Endoscopic retrograde cholangiopancreatography (ERCP) with removal of calculi/debris from biliary/pancreatic duct(s), with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)		X
C7550	Cystourethroscopy, with biopsy(ies) with adjunctive blue light cystoscopy with fluorescent imaging agent		X
C7554	Cystourethroscopy with adjunctive blue light cystoscopy with fluorescent imaging agent		X
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi		X
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus		X

ESRD Medical Evidence Report HCFA-2728

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS

1. Name *(Last, First, Middle Initial)*

2. Health Insurance Claim Number

3. Social Security Number

4. Full Address *(Include City, State and Zip)*

5. Phone Number
( )

6. Date of Birth
_____/_____/_____
MM DD YYY

7. Sex
_ Male_ Female

8. Ethnicity
_ Hispanic: Mexican_ Hispanic: Other_ Non-Hispanic

9. Race (Check one box only)
_ White_ Mid-East/Arabian
_ Black_ Indian sub-Continent
_ American Indian/Alaskan Native_ Other or Multiracial
_ Asian_ Unknown
_ Pacific Islander

10. Medical Coverage (Check all that apply)
a. _ Medicaide. _ Other Medical Insurance
b. _ DVAf. _ None
c. _ Medicare
d. _ Employer Group Health Insurance

11. Is Patient Applying for ESRD Medicare Coverage? (if YES, enter address or social security office)
ADDRESS
_ Yes_ No

CITYSTATEZIP

12. Primary Cause of Renal Failure *(Use code from back of form)*

13. Height

14. Dry Weight

INCHES OR CENTIMETERS

POUNDS OR KILOGRAMS

15. Employment Status (6 mos prior and current status)

16. Co-Morbid Conditions (Check **ALL** that apply currently or during last 10 years) *See instructions

Prior	Current				
		a. _	Congestive heart failure	k. _	Diabetes, currently on insulin
		b. _	Ischemic heart disease, CAD*	l. _	Chronic obstructive pulmonary disease
_	_	Unemployed	c. _ Myocardial infraction	m. _	Tobacco use (current smoker)
_	_	Employed Full Time	d. _ Cardiac arrest	n. _	Malignant neoplasm, Cancer
_	_	Employed Part Time	e. _ Cardiac dysrhythmia	o. _	Alcohol dependence
_	_	Homemaker	f. _ Pericarditis	p. _	Drug dependence*
_	_	Retired due to Age/Preference	g. _ Cerebrovascular disease, CVA, TIA*	q. _	HIV positive status_ Can't Disclose
_	_	Retired (Disability)	h. _ Peripheral vascular disease*	r. _	AIDS_ Can't Disclose
_	_	Medical Leave of Absence	i. _ History of hypertension	s. _	Inability to ambulate
_	_	Student	j. _ Diabetes (primary or contributing)	t. _	Inability to transfer

17. Was pre-dialysis/transplant EPO administered?
_ Yes_ No

18.Laboratory Values Prior to First Dialysis Treatment or Transplant *See instructions

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Hematocrit (%)			e. Serum Creatinine (mg/dl)		
b. Hemoglobin (g/dl)*			f. Creatinine Clearance (ml/min)*		
c. Serum Albumin (g/dl)			g. BUN (mg/dl)*		
d. Serum Albumin Lower Limit (g/dl)			h. Urea Clearance (ml/min)*		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT.

19. Name of Provider	20. Medicare Provider Number
21. Primary Dialysis Setting _ Hospital Inpatient _ Dialysis Facility Center_ Home	22. Primary Type of Dialysis _ Hemodialysis_ IPD_ CAPD_ CCPD_ Other
23. Date Regular Dialysis Began _____/_____/_____ MMDDYY	24. Date Patient Started at Current Facility _____/_____/_____ MMDDYY

25. Date Dialysis Stopped _____/_____/_____ MMDDYY	26. Date of Death _____/_____/_____ MMDDYY

ESRD Medical Evidence Report (back)

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant _____/_____/_____ MM DD YY	28. Name of Transplant Hospital	29. Medicare Provider Name for Item 26

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

30. Enter Date _____/_____/_____ MM DD YY	31. Name of Preparation Hospital	32. Medicare Provider Number for Item 31

33. Current Status of Transplant
_ Functioning_ Non-Functioning

34. If Nonfunctioning, Date of Return To Regular Dialysis _____/_____/_____ MM DD YY	35. Current Dialysis Treatment Site _ Hospital Inpatient_ Dialysis Facility/Center_ Home

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

36. Name of Training Provider	37. Medicare Provider Number of Training Provider
38. Date Training Began _____/_____/_____ MM DD YY	39. Type of Training _ Hemodialysis_ IPD_ CAPD_ CCPD
40. This Patient is Expected to Complete *(or has completed)* Training and Will Self-dialyze on a Regular Basis. _ Yes_ No	41. Date When Patient Completed, or is Expected to Complete, Training _____/_____/_____ MM DD YY

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

42. Printed Name and Signature of Physician personally familiar with the patient's training	43. UPIN of Physician in Item 42

E. PHYSICIAN IDENTIFICATION

44. Attending Physician *(Print)*	45. Physician's Phone No. ( )	46. UPIN of Physician in Item 44

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

47. Attending Physician's Signature of Attestation (Same as Item 44)	48. Date _____/_____/_____ MM DD YY

49. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

50. Signature of Patient *(Signature by mark must be witnessed)*	51. Date _____/_____/_____ MM DD YY

G. PRIVACY ACT STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520. "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Privacy Act Issuance, 1991 Compilation, Vol. 1, pages 436-437, December 31, 1991 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for a research, demonstrator, evaluator, or epidermiologic project related to the prevention of disease or disability, or the restoration of maintenance of health. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

H. FOR ESRD NETWORK USE ONLY IN CASES REFERRED TO ESRD MEDICAL REVIEW BOARD

52. Network Confirmed as ESRD _ Yes_ No	53. Authorized Signature	54. Date _____/_____/_____ MM DD YY	55. Network Number

(Insert Year) Expedited Organization Determination Tracking Log

[ ] No Activity for the Month:
PPG Name: _____
PPG ID Number: _____

Date: _____
Submitted by:_____
Phone/Email:_____

PPG Case ID#	Date/ Time Received	Member Name	Member ID#	Meets EOD Criteria* [Yes/No]	Date/ Time Decision	Member Date/Time Oral Notice	Provider Date/Time Oral Notice	Date/ Time Written Notice	Extension [Yes/No]	Decision [Approved/ Denied]	Service Type

Please E-mail this completed form by the 15th of the month via Secure Messaging to:
UMQIMR@healthnet.com
or you may
fax to the Program Accreditation E-Fax: (877) 890-4105

Due to HIPAA privacy requirements, documents containing protected health information should not be submitted via unsecured e-mail.

Provider Reporting

Data File Record Layouts

SENIORITY PLUS

File Name: ACTIVITY
Report Number: SPC_RPT_BRM_30

All records in this file are 297 bytes long. This file has three record types: Header, Detail and Trailer. Data expressed in the "X" format is left justified and blank filled. Data expressed in the "9" format is right justified and zero filled.

Header Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"1" = Header record
Title	002-009	X(8)	"ACT HDR"
Activity Start	010-017	X(8)	CCYYMMDD, first day of activity included in file
Activity End Date	018-025	X(8)	CCYYMMDD, last day of activity included in file
Provider Type	026-026	X(1)	"M" = Medical Provider "H" = Hospital Provider
Provider ID	027-030	X(4)	PPG or Hospital number
Provider Name	031-063	X(33)	PPG or Hospital name
Address	064-088	X(25)	PPG or Hospital address
City	089-105	X(17)	PPG or Hospital city
State	106-107	X(2)	PPG or Hospital state
Zip Code	108-116	X(9)	PPG or Hospital zip code
Filler	117-297	X(181)	Blank Spaces (Not Used)

Detail Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"2" = Detail record
Member's Last Name	002-018	X(17)	Member's last name
Member's First Name	019-028	X(10)	Member's first name
Member's Middle Initial	029-029	X(1)	Member's middle initial
Subscriber ID	030-038	X(9)	Subscriber's social security number
Group ID	039-046	X(8)	Member's employer group number
Cin Number	047-055	X(9)	Cin Number
Aid code	056-057	X(2)	Aid code
Aid category	058-060	X(3)	Aid category
Project code	061-063	X(3)	Project code
Medicare stat A	064-064	X(1)	Medicare stat A
Medicare Stat B	065-065	X(1)	Medicare Stat B
Medicare stat D	066-066	X(1)	Medicare stat D
Contract Type	067-067	X(1)	Contract Type
Plan Code	068-071	X(4)	Medical plan of the employer group that the member belongs to
Member Code	072-074	X(3)	A code that describes a member's sex and relationship to the subscriber. (See Member Code Table for Values)
Age	075-077	X(3)	Member's age as of the last day of the month

Birth date	078-085	X(8)	CCYYMMDD Member's birth date
Dialysis Indicator	086-086	X(1)	Member Dialysis Indicator
Physician's ID	087-092	X(6)	Health Net assigned PCP
Effective Date	093-100	X(8)	CCYYMMDD, date the member is eligible for benefits
Cancel Date	101-108	X(8)	CCYYMMDD, effective cancellation date with the medical group
Information Effective Date	109-116	X(8)	CCYYMMDD, effective date of the update
Information Update Date	117-124	X(8)	CCYYMMDD, business date the update was processed
Information Update Time	125-132	X(8)	HHMMSSHS, time of the day the update was processed
Change Type	133-134	X(2)	Code indicating the type of change processed
Change Description	135-149	X(15)	Description of the change reported
Address 1	150-174	X(25)	Member's address
Address 2	175-199	X(25)	Member's address continued
City	200-216	X(17)	Member's city
State	217-218	X(2)	Member's state
Zip Code	219-227	X(9)	Member's zip code
Home Phone	228-237	X(10)	Member's Home Phone
Filler	238-243	X(6)	Blank Spaces (Not Used)
Medicare Part A Status	244-244	X(1)	Member's Medicare part A status (See Member Status Table for Values)
Medicaid Status	245-245	X(1)	Member's Medicaid status (See Member Status Table for Values)
Member Status	246-246	X(1)	Member's Medicaid status (See Member Status Table for Values)
Working Aged	247-247	X(1)	Member's working status (See Member Status Table for Values)
PR TY	248-248	X(1)	Product type
Provider ID	249-252	X(4)	Provider ID
Medicaid Add On	253-253	X(1)	Medicaid Add On "Y" or "N"
Previously Disabled	254-254	X(1)	Previously Disabled "Y" or "N"
Default Risk Indicator	255-255	X(1)	Default risk indicator "Y" or "N"
PIP / DCG Code	256-257	9(2)	PIP / DCG code
SCC	258-262	9(5)	State county code
Product Code	263-266	X(4)	Product code
Reference ID	267-275	X(9)	
DTL Provider Type	276-276	X(1)	DTL Provider Type
DTL Provider ID	277-280	X(4)	DTL Provider ID
DTL Physician ID	281-286	X(6)	DTL Physician ID
Filler	287-297	X(11)	Blank Spaces (Not Used)

Trailer Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"4" = Trailer record
Title	002-009	X(8)	"ACT SUM"
Member Add's	010-017	9(8)	Total number of members added
Member Cancels	018-025	9(8)	Total number of members cancelled
Record Counts	026-033	9(8)	Total number of "detail" records on the file
TTL MBR SPC	034-041	9(8)	Total SPC member count
TTL MBR SP1	042-049	9(8)	Total SP1 member count
Filler	050-297	X(248)	Blank Spaces (Not Used)

Provider Reporting

Data File Record Layouts

SENIORITY PLUS

File Name: EXPANDED ELIGIBILITY
Report Number: SPC_RPT_BRM_42

All records in this file are 441 bytes long. There are four record types: Header, Detail, COB, and the Trailer record. Data expressed in the "X" format is left justified and blank filled, data expressed in the "9" format is right-justified and zero filled.

Old Record Layout Size = 309

New Record Layout Size = 441

Header Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"1" = Header record
Title	002-009	X(8)	"ELIG HDR"
Info Effective Date	010-017	X(8)	CCYYMMDD, effective date
Provider Type	018-018	X(1)	"M" = Medical Provider - "H" = Hospital Provider
Provider ID	019-022	X(4)	PPG, or Hospital Number
Provider Name	023-055	X(33)	PPG, or Hospital Name
Address	056-080	X(25)	PPG, or Hospital Address
City	081-097	X(17)	PPG, or Hospital City
State	098-099	X(2)	PPG, or Hospital State
Zip Code	100-108	X(9)	PPG, or Hospital Zip Code
Filler	109-441	X(333)	Blank Spaces (Not Used)

Detail Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"2" = Detail Record
Member's Last Name	002-018	X(17)	Member's Last Name
Member's First Name	019-028	X(10)	Member's First Name
Member's Middle Initial	029-029	X(1)	Member's Middle Initial
Subscriber ID	030-038	X(9)	Sent as blanks
Group ID	039-046	X(8)	Health Net Employer / Individual Group Number
Member Code	047-049	X(3)	A code that describes the member's sex and a member's relationship to the subscriber
Insight Indicator	050-050	X(1)	Y/N Member has Mental Health Benefits
Plan Code	051-054	X(4)	Medical Plan of the employer / individual group the member belongs to
Office Visit Co-pay	055-057	X(3)	Office Visit Co-pay
DME Benefit	058-060	X(3)	Durable Medical Equipment benefit Co-pay
ER Benefit	061-063	X(3)	Emergency Room Co-pay
COB Carrier ID	064-071	X(8)	COB Carrier ID

CIN Number	072-080	X(9)	Member CIN # (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Aid Code	081-082	X(2)	Member Aid Code (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Aid Category	083-085	X(3)	Member Aid Category (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Project Code	086-088	X(3)	Member Project Code (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Medicare Status A	089-089	X(1)	Medicare Part A flag for the member (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Medicare Status B	090-090	X(1)	Medicare Part B flag for the member (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Medicare Status D	091-091	X(1)	Medicare Part D flag for the member (will be populated only for Duals and Medicaid members, will be blanks for Medicare)
Birth date	092-099	X(8)	CCYYMMDD, Member's birth date
Satellite Provider ID	100-103	X(4)	Used only for consolidated files. Displays site where member is enrolled
Physician ID	104-109	X(6)	If physician level report, Health Net assigned PCP number, otherwise will be PPG number
Provider Effective Date	110-117	X(8)	CCYYMMDD, the date member is effective with this medical group
Cancel Effective Date	118-125	X(8)	CCYYMMDD, the date member cancelled with this medical group
Product Code	126-129	X(4)	“MCR”=Medicare, “SDE” = Medicare SNP
Fund Type	130-130	X(1)	Fund Type
Rx Indicator	131-131	X(1)	Y/N. “N” if member OPT-OUT of Medicare Part D
Pr Ty	132-132	X(1)	Priority Type
Member Address 1	133-182	X(50)	Member's Address
Member City	183-199	X(17)	Member's City
Member State	200-201	X(2)	Member's State
Member Zip Code	202-210	X(9)	Member's Zip Code
Member Phone Number	211-220	X(10)	Member's Home Phone Number
Member Reference ID	221-229	X(9)	Member Reference ID
Medi-Medi indicator	230-230	X(1)	Medicaid indicator
CMS MBI	231-242	X(12)	CMS MBI
CMS Status	243-243	X(1)	0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized, 4 = Working Aged
Filler	244-244	X(1)	Blank Spaces (Not Used)
Spoken_language	245-247	X(3)	Member’s spoken language
Written_language	248-250	X(3)	Member’s written language
Race	251-253	X(3)	Member’s Race
Ethnicity	254-256	X(3)	Member’s Ethnicity
Dialysis Indicator	257-257	X(1)	Member Dialysis Indicator
Alternate Format	258-260	X(3)	Member Alternate Format
Person ID	261-271	X(11)	Person ID
PCP Name	272-301	X(30)	PCP Name

PBP	302-304	X(3)	Plan Benefit Package
CMS ID	305-309	X(5)	Centers for Medicare & Centers for Medicare & Medicaid Services Identification
RAF	310-314	X(5)	Risk Adjustment Factor
OHC Policy ID	315-329	X(15)	Other Health Coverage Policy ID (or “SSN”)
Filler	330-441	X(112)	Blanks

COB Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"3" = COB Record
COB Carrier ID	002-009	X(8)	COB ID
COB Carrier Name	010-039	X(30)	COB Carrier Name
OHC Address 1	040-064	X(25)	Carrier Address 1
OHC Address 2	065-089	X(25)	Carrier Address 2
OHC City	090-106	X(17)	Carrier City
OHC State	107-108	X(02)	Carrier State
OHC Zip Code	109-119	X(11)	Carrier Zip Code
Carrier phone 1	120-134	X(15)	Carrier Phone 1
Carrier phone 2	135-149	X(15)	Carrier Phone 2
Carrier phone 3	150-164	X(15)	Carrier Phone 3
OHC Remark 1	165-214	X(50)	OHC Remark 1
OHC Remark 2	215-264	X(50)	OHC Remark 2
Filler	265-441	X(177)	Blank Spaces (Not Used)

Trailer Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"4" = Trailer Record
Title	002-009	X(8)	"ELIG SUM"
Total Members EOM	010-017	9(8)	Total Members as of month end
Total Members in Month	018-025	9(8)	Total members eligible at least one day of the month
TTL MBR SPC	026-033	9(8)	Total SPC member count
TTL MBR SPC	034-041	9(8)	Total SP1 member count
Filler	042-441	X(400)	Blank Spaces (Not Used)

Government Programs Electronic Media Format
Member Status Table

Member Status Table	
Field Name	**Values**
Medicare Part A Status	Y = Part A N = Part A Equivalent
Medicaid Status	Y = Yes N = No
Member Status	0 = Standard 1 = ESRD 2 = Hospice 3 = Institutionalized
Working Aged	Y = Yes N = No

Provider Reporting

Data File Record Layouts

SENIORITY PLUS

File Name: REMITTANCE DETAIL
Report Number: SPC_RPT_BRM_20

All records in this file are 161 bytes long. There are three record types: Header, Detail and Trailer. Data expressed as an "X" format is left justified and blank filled. Data expressed as "9" format is right justified and zero filled. All dollar amount fields are signed (-, +) and contain assumed decimals.

Header Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"1" = header record
Title	002-009	X(8)	"REM HDR"
Information Effective Date	010-017	X(8)	CCYYMMDD, Remittance Effective Date
Provider Type	018-018	X(1)	"M" = Medical Provider "H" = Hospital Provider
Provider ID	019-022	X(4)	PPG or Hospital number
Provider Name	023-055	X(33)	PPG or Hospital name
Address	056-080	X(25)	PPG or Hospital address
City	081-097	X(17)	PPG or Hospital city
State	098-099	X(2)	PPG or Hospital state
Zip Code	100-108	X(9)	PPG or Hospital zip code
Filler	109-157	X(49)	Blank

Detail Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"2" = detail record
Last Name	002-018	X(17)	Member's last name
First Name	019-028	X(10)	Member's first name
Middle Name	029-029	X(1)	Member's middle initial
Subscriber ID	030-038	X(9)	Subscriber's social security number
Group ID	039-046	X(8)	Member's employer group number
Cin number	047-055	X(9)	Cin number
Aid code	056-057	X(2)	Aid code
Aid category	058-060	X(3)	Aid category
Project code	061-063	X(3)	Project code
Medicare stat A	064-064	X(1)	Medicare stat A
Medicare Stat B	065-065	X(1)	Medicare Stat B
Medicare stat D	066-066	X(1)	Medicare stat D
Member Code	067-069	X(3)	Member Code
Satellite Provider ID	070-073	X(4)	Used only for consolidated files. Reflects site where member is enrolled
Physician ID	074-079	X(6)	If physician level report this number will be a Health Net assigned PCP number

Plan Code	080-083	X(4)	Medical plan of the employer group the member belongs to
Contract Type	084-084	X(1)	Contract Type
Age	085-087	X(3)	Member's age as of the last day of the month
Birth date	088-095	X(8)	CCYYMMDD Members birth date
Remittance effective month	096-101	X(6)	CCYYMM effective month for the adjustment
Change description	102-116	X(15)	Description of the change reported
Adjustment Amount	117-123	s9(5)v99	Net amount of adjustment
Dialysis Indicator	124-124	X(1)	Member Dialysis Indicator
Filler	125-128	X(4)	Filler
Medicare Part A stat	129-129	X(1)	Part A status
Medicaid Stat	130-130	X(1)	Member's Medicaid status (Y/N)
Member status	131-131	X(1)	Member's Medicare status (O=Standard, 1=ESRD, 2=Hospice, 3=Institutionalized)
Working aged	132-132	X(1)	Member's working aged status
Priority Type	133-133	X(1)	Priority Type
Medicaid Add On	134-134	X(1)	Y = Entitled to Medicaid Add On
Previously disabled	135-135	X(1)	Y = Original reason of entitlement
Default risk indicator	136-136	X(1)	Y = Default factor used
PIP DCG Code	137-138	9(2)	Member's risk adjustor code
SCC Code	139-143	9(5)	Member's state and county code that the % of HCFA payment is based on
Reference ID	144-152	X(9)	Member Reference ID
Filler	153-160	X(8)	Blanks

Trailer Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"4" = trailer record
Title	002-009	X(8)	"REM SUM"
Total Remittance Adjustments to Prior Periods	010-020	s9(9)v99	Total of the net remittance adjustments applied in the current month for prior periods
Total Remittance Rates	021-031	s9(9)v99	Total remittance rates for each member for the current month (without any adjustments)
Total of Remittance Adjustments to Current Periods	032-042	s9(9)v99	Total adjustments applied to the current month rates
Total Remittance Amount	043-053	s9(9)v99	Total current month remittance equal to (total prior period adjustments + total current period rates + total current period adjustments)
Total Remittance Records	054-061	9(8)	Total detail records on the file
TTL MBR SPC	062-069	9(8)	Total SPC member count
TTL MBR SP1	070-077	9(8)	Total SP1 member count
Filler	078-153	X(76)	Blanks

HEPATITIS B VACCINATION DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Signature of Employee Date

<Date>

RE: Hospice Consideration Request

Dear Dr. <Last name of Physician>:

Your patient **<insert first name> <insert last name>** has been identified as a potential candidate for hospice care. In accordance with Section 1861(ee)(2)(D) of the Social Security Act (SSA), all patients meeting the requirements for hospice must be offered the option of hospice as part of their discharge planning. This is a best practice for commercial patients as well as Medicare patients.

As the physician, you are in a vital position to help decide the next steps or treatment phase for your patient. Since you are the person on whom your patient relies and most trusts for medical advice, it is very important that your patient learn about treatment options from you. It will also help the patient and the patient's family feel more comfortable with hospice if they have already discussed treatment options with you.

To assist you with your discussion of hospice as one of the options for your patient, we have enclosed *Criteria for Hospice Appropriateness*. Please do not hesitate to contact me if you have any questions.

Thank you.

_____ _____

Print name of social worker/case manager Signature

_____

(Telephone or pager number)

_____ _____

Print name of attending nurse Signature of attending nurse

_____

(Telephone or pager number)

Enclosures (2)

06-263

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HOSPITAL REINSURANCE EXAMPLE

The first dollar attachment point signifies the point at which reinsurance begins using the percentage reinsured. The second dollar attachment point signifies the point at which the reinsurance is increased. The PPG has selected a first attachment point of $80,000. The PPG has selected a second attachment point of $150,000.

Examples are as follows:

1.	Becky Smith	Dates of Service 04/01/01 thru 05/01/01	$100,000 total claims
		$.01 through $80,000	Charged to shared risk
		$80,000 through $150,000	Reinsurance @ 80% (20%is charged to shared risk)
		Charged to shared risk	
		First Attachment Point:	$80,000
		Second Point:	4,000
		($100,000 - $80,000) x 20%	$84,000
		Covered by Reinsurance	$16,000
		$100,000 - $84,000	
2.	Karen Miller	Dates of Service 06/01/01 thru 09/01/01	$250,000 total claims
		$.01 through $80,000	Charged to shared risk
		$80,000 through $150,000	Reinsured @ 80% (20% is charged to shared risk)
		$150,000 through $250,000	Reinsured @ 90% (10% is charged to shared risk)
		Charged to shared risk	
		First Attachment Point:	$80,000
		Second Point	$14,000
		($150,000 - $80,000) x 20%	$10,000
		($250,000 - $150,000) x 10%	$104,000
		Covered by Reinsurance	$146,000
		$250,000 - $104,000	
3.	John Jones	Dates of Service 01/01/01 thru 02/01/01	$500,000 total claims
		$.01 through $80,000	Charged to shared risk
		$80,000 through $150,000	Reinsured @ 80% (20% is charged to shared risk)
		$150,000 through $500,000	Reinsured @ 90% (10% is charged to shared risk)
		Charged to shared risk	
		First Attachment Point:	$80,000
		Second Point	$14,000
		($150,000 - $80,000) x 20%	$35,000
		($500,000 - $150,000) x 10%	$129,000
		Covered by Reinsurance	
		$500,000 - $129,000	$371,000

FRONT PANEL

Seniority Plus Employer (HMO) MA Only
CMS#: <H0562-XXXX>
Effective Date: <MM/DD/YYYY>

MEMBER INFORMATION
Name: <First MI Last>
Member ID#: <XXXXXXXXX-XXX>
HN Group ID: <XXXXXX>

PROVIDER INFORMATION
PPG Name: < >
PPG Phone: < >
PCP Name: < >
PCP Phone: < >
PCP Office Visit: $X

PHARMACY INFORMATION

Part B Drugs Only
Rx Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <HNET>
RXGRP: <HNET>

BACK PANEL

ca.healthnetadvantage.com

FOR MEMBERS
Member Services: <1-800-275-4737 (**TTY:** 711)>
Mental Health Benefits: <1-800-646-5610 (**TTY:** 711)>
24-hr Nurse Advice: <1-800-893-5597 (**TTY:** 711)>

FOR EMERGENCIES
Dial 911 or go to the nearest Emergency Room (ER).

FOR PROVIDERS

For Member eligibility, Medical prior authorization or case management referrals: <1-800-929-9224>

Medical Claims: <Health Net> <Attn: Claims>
Payor ID: <68069> <P.O. Box 9030 Farmington, MO 63640-9030>

Pharmacy prior auth: <1-800-867-6564>
For help with Part B Drugs: (PHARMACY USE ONLY) <1-888-865-6567>

APRON

Enclosed is your new Health Net member identification card. Please discard any old identification cards you may have from Health Net.

You'll want to take a few minutes to carefully review all of the information on the card, including the spelling of your name. Also, be sure the PCP you selected matches what is on your ID card. If it doesn't, please call Member Services at 1-800-275-4737 (TTY: 711) so we can fix that for you. If you didn't select a PCP, we selected one for you; but don't worry, you can choose a new PCP by calling Member Services at the number noted above.

Your ID card is very important so be sure to have it with you and show it at all of your healthcare appointments.

Thank you for choosing Health Net. We appreciate the trust you put in us and look forward to serving you.

Material ID# Y0020_MAONLY2022CARD_C Internal Approval 07222021

FRONT PANEL

health net

Health Net
Seniority Plus Employer (HMO)
CMS#: <H0562-XXXX>
Effective Date: <MM/DD/YYYY>

MEMBER INFORMATION
Name: <First MI Last>
Member ID#: <XXXXXXXXX-XXX>
HN Group ID: <XXXXXX>

PROVIDER INFORMATION
PPG Name: < >
PPG Phone: < >
PCP Name: < >
PCP Phone: < >
PCP Office Visit: $X

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage

Rx Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: <RX6270>

BACK PANEL

ca.healthnetadvantage.com

FOR MEMBERS
Member Services: <1-800-275-4737 (**TTY:** 711)>
Mental Health Benefits: <1-800-646-5610 (**TTY:** 711)>
Nurse Advice Line: <1-800-893-5597 (**TTY:** 711)>

FOR EMERGENCIES
Dial 911 or go to the nearest Emergency Room (ER).

FOR PROVIDERS
For Member eligibility and Medical prior auth/referrals : <1-800-929-9224>

Medical Claims: <Health Net> <Attn: Claims>
Payor ID: <68069> <P.O. Box 9030 Farmington, MO 63640-9030>

Pharmacy prior auth: <1-800-867-6564>
For help: (PHARMACY USE ONLY) <1-888-865-6567>
Submit Part D Drug Claims to:<Health Net> <Attn: Member Reimbursement Dept>
<P.O. Box 31577, Tampa, FL 33631-3577>

APRON

Enclosed is your new Health Net member identification card. Please discard any old identification cards you may have from Health Net.

You'll want to take a few minutes to carefully review all of the information on the card, including the spelling of your name. Also, be sure the PCP you selected matches what is on your ID card. If it doesn't, please call Member Services at 1-800-275-4737 (TTY: 711) so we can fix that for you. If you didn't select a PCP, we selected one for you; but don't worry, you can choose a new PCP by calling Member Services at the number noted above.

Your ID card is very important so be sure to have it with you and show it at all of your healthcare appointments.

Thank you for choosing Health Net. We appreciate the trust you put in us and look forward to serving you.

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FRONT PANEL

wellcare By health net

Wellcare By Health Net
<Product Name>
CMS#: <HXXXX-XXX>
Effective Date: <MM/DD/YYYY>

MEMBER INFORMATION
Name: <First MI Last>
Member ID#: <XXXXXXXXX-XXX>
Issuer ID: <(80840)> <9151014609>

PROVIDER INFORMATION
PPG Name: < >
PPG Phone: < >
PCP Name: < >
PCP Phone: < >
PCP Office Visit: $X

PHARMACY INFORMATION
MedicareRx Prescription Drug Coverage

Rx Claims Processor:
<CVS Caremark®>
RXBIN: <XXXXX>
RXPCN: <XXXXXXX>
RXGRP: <XXXXXX>

FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).

BACK PANEL

www.wellcare.com/healthnetCA

FOR MEMBERS

Member Services	<1-800-431-9007 (**TTY:** 711)>
Mental Health Benefits	<1-800-646-5610 (**TTY:** 711)>
Nurse Advice Line	<1-800-893-5597 (**TTY:** 711)>
Transportation	<1-866-653-0975 (**TTY:** 711)>
Liberty Dental (For Members and Providers)	<1-888-700-3612 (**TTY:** 711)>
Envolve Vision (For Members and Members)	<1-866-392-6058 (**TTY:** 711)>

FOR PROVIDERS

For Member eligibility and Medical prior auth/referrals : <1-800-431-9007>
Medical Claims: <Wellcare By Health Net> <Attn: Claims>
Payor ID: <68069> <P.O. Box 9030 Farmington, MO 63640-9030>

Pharmacy prior auth: <1-800-867-6564>
For help: (PHARMACY USE ONLY) <1-888-865-6567>
Submit Part D Drug Claims to:<Wellcare By Health Net> <Attn: Member Reimbursement Dept> <P.O. Box 31577, Tampa, FL 33631-3577>

APRON

Enclosed is your new Wellcare By Health Net member identification card. Please discard any old identification cards you may have from Wellcare By Health Net.

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Your ID card is very important so be sure to have it with you and show it at all of your healthcare appointments.

Thank you for choosing Wellcare By Health Net. We appreciate the trust you put in us and look forward to serving you.

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wellcare By health net

HEALTH INDUSTRY COLLABORATION EFFORT

Simplifying Healthcare Administration

Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

Provider Communications

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

On behalf of the ICE Cultural and Linguistic Workgroup,

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SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is

1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

---

[1] Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations**- *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion**- *asks about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identifies your patient's language needs including health literacy levels. Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment –** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as "*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*"

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

✓ Use simple words and avoid jargon. ✓ Never use acronyms. ✓ Avoid technical language (if possible). ✓ Repeat important information – a patient's logic may be different from yours. ✓ Ask patients to repeat back to you important information. ✓ Ask open-ended questions. ✓ Use medically trained interpreters familiar with cultural nuances.	✓ Give information in small chunks. ✓ Articulate words. ✓ "Read" written instructions out load. ✓ Speak slowly (don't shout). ✓ Use body language to support what you are saying. ✓ Draw pictures, use posters, models or physical demonstrations. ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

Use **Ask Me 3®**[2]. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

INTERVIEW QUESTIONS

Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.*

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.*

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?*

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.*

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

EFFECTIVE COMMUNICATION

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

AUXILIARY AIDS AND SERVICES

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key.
For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

COMPANIONS

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the ADA, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	**These are some options we can provide for you…..**
Am blind or have vision impairments that keep me from reading	- Large print materials - Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped https://www.loc.gov/nls/pdf/application.pdf - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older- People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:
The KEY to Patient Engagement

Where do I start?
Check out the Q&A below to learn more...

Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:
- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

Go: *pull it all together, implement, evaluate, plan for the future*

What language service needs should I begin to identify?

Keep it simple and write down:
- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!
- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!
- Review resources and identify those most useful for your office

Go!
- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies. and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit http://ddtp.cpuc.ca.gov/homepage.aspx

Teletype Device

Relay Operator

Cell or Landline Phone

SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B

RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent
- answers to your questions
- Member may have trouble communicating in English or you may have a
- very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

"*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

OR

"*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

"*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak…." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

TIPS FOR WORKING WITH INTERPRETERS

TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

When the interpreter comes onto the line let the interpreter know the following: **

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.**

ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **

- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
  Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

1) Identify the languages spoken by your patients, and
2) Identify the language services available to meet these needs

For example:

Language spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in person interpreter

Identify the language capability of your staff (See Employee Language Skills Self-Assessment)
• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency
• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. ***IF you use a minor, document the reason a minor was used.***

<u>Identify services available</u> do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry Collaboration Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic العربية
أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Armenian Հայերեն
Նշեք, թե որ լեզվով եք խոսում: Թարգմանիչ կկանչենք: Թարգմանչի ծառայությունները տրամադրվում են անվճար:

Bengali বাংলা
আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বোভাষীকে ডাকা হবে। দ্বোভাষী আপনি নিখরচায় পাবেন।

Cambodian (Khmer) ខ្មែរ (កម្ពុជា)
សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។

Chinese (Cantonese) 廣東話
請指認您的語言，以便為您提供免費的口譯服務。

Chinese (Mandarin) 普通话
请指认您的语言，以便为您提供免费的口译服务。

Farsi (Persian) فارسي
زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

Greek Ελληνικά
Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.

Hindi हिंदी
अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।

Hmong Hmoob
Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Japanese 日本語
あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean 한국어
귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.

Portuguese Português
Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi ਪੰਜਾਬੀ
ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Russian Русский
Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Samoan Fa`asamoa
Fa`asino lau gagana. Ole a vala`au se fa`amatala`upu. Ua saunia se fa`amatala`upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Español
Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai ไทย
ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย

Tongan Tongan Lea Faka-Tonga
Tuhu`i mai ho`o lea fakafonua. `E ui ha fakatonulea. `Oki ta`etotongi kia `a e fakatonulea.

Urdu اردو
اپنی زبان پر اشارہ کریں- ایک ترجمان کو بلاجائے گا- ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا-

Vietnamese Tiếng Việt
Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

Provided courtesy of Industry Collaboration Effort and LanguageLine Solutions.

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COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中文	*Chinese*	歡迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieâït	*Vietnamese*	Phòng vệ sinh
中文	*Chinese*	洗手間

Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**

Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Cl
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Courtesy statements	***Frases de cortesía***	***Từ ngữ lịch sự***	
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Patient may say….	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	***病***
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

Patient may say…	*El paciente puede decir…*	*Bệnh nhân có thể nói...*	*病人可能會說...*
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？

Point to a sentence **Señale una frase** **Xin chỉ vào câu** **指向句子**

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員可能會問或說。。。*
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	
Point to a sentence	Señale una frase	Xin chỉ vào câu	

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員*
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現*

Point to a sentence	Señale una frase	Lonje dwèt ou sou yon fraz

Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kr
Point to a sentence	**Señale una frase**	**Lonje dwèt ou s**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Ko***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an ka*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè dokè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	ske mwen ka gen yon entèprèt?

Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab di oubyen mande...**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka ѣ pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon enѣpѣt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon enѣpѣt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Krey
Point to a sentence	Señale una frase	Lonje dwèt ou sou
Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **po**
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou
Now, fill out these forms, please	*Ahora, por favor conteste estas formas.*	*Kounye a, ekri enfimasyon yo ma*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.
Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ **Department/Job Title:** _____

_____

Work Days: **Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun** **Work Hours (Please Specify):** _____

_____

Directions: (1) List any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language

Language	**Dialect, region, or country**	**Fluency: see attached key (Circle)**			**I would like to use my language skills to speak with patients (Circle)**	**I would like to use my reading language skills to communicate with patients (Circle)**	**I would like to use my language skills to write patient communications (Circle)**
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?

SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: http://minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities…

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit https://www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website https://www.thinkculturalhealth.hhs.gov , sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, http://minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, http://minorityhealth.hhs.gov
- Think Cultural Health, https://www.thinkculturalhealth.hhs.gov

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
Confidentiality Preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020[2], LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.

Visit glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit glaad.org for additional resources on how to fairly and accurately report on transgender people

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- **GLMA cultural competence webinar series**
- **Providing Enhanced Resources Cultural Competency Training**
- **LGBT Health Resources**
- **Equal Employment Opportunity Commission** for your local EEOC field office
- **Creating an LGBT Friendly Practice**
- **LGBT Training Curricula for Behavioral Health and Primary Care Practitioners**
- **Preventing Discrimination**
- **Bullying Policies & Laws**

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
    - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
    - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
    - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.

- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand,	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
Beliefs About Drug Addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

		what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **Note: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.1

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Other federal and state legislation protecting the right to "equal care" outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued "Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.
The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity
  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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www.whitehouse.gov/omb/fedreg_race-ethnicity

www.who.int.healthsystems/topics/equity

CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier

an obstacle, impediment, obstruction, boundary, or separation.

Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication

the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

Disability

any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity

an avoidable and unfair difference in health status between segments of the population.

Health Literacy

the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation
: In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
: one who translates orally for parties conversing in different languages.

Language
: the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
: is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
: Anything intended to aid memory.

Race
: the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
: an asset valuable commodity or service.

Service
: help or assistance.

Speech
: the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
: a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
: a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
: an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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Guidance to Comply with New Interpreter Quality Standards
Requirements on the use of Bilingual/Multilingual Staff as Interpreters

Summary of Requirements and Documentation		
Requirement	**Potential Evidence**	**Provider Office to Note Documentation of Qualification**
Office has a documented policy to offer interpreter support to LEP patients	☐ Local office written policy; or ☐ Local office policy that defers and adheres to the policy distributed by medical group Note: Policy includes documentation of patient language needs in medical record	Written policy available for viewing by an auditor Policy title:
Adheres to generally accepted interpreter ethics principles, including client confidentiality	Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at: http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf	Signed attestations are available. ☐ Yes ☐ No
Has *demonstrated* proficiency in speaking and understanding both spoken English and at least one other spoken language	☐ Formal assessment of proficiency; or ☐ Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology	☐ Formal assessment of proficiency; or Annual performance evaluations document ☐ Ability to interpret effectively, ☐ Ability to interpret accurately, ☐ Ability to interpret impartially, ☐ Ability to interpret receptively and expressly, ☐ Ability to interpret to and from English and another language using any **necessary specialized vocabulary terminology and phraseology** Note: see NCIHC Interpreter Code of Ethics for description of above.	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D. **http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf**		

Language Proficiency Assessment Resources

The bilingual assessment vendors included on this list are suggestions that providers might consider if they choose to use a bilingual assessment vendor to help ensure that they are using qualified bilingual staff to provide patient care, as these organizations have self-attested that they meet the required criteria. However, that should not be considered an endorsement for any language service vendor by ICE. The ICE C&L Team has not in the past and does not now endorse any language service vendors.

Language Proficiency Assessment Resources						
		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Berkeley Language Institute (BLI) Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).	http://www.berkeleylanguageinstitute.com/index.html 1-510-655-9469 Marci Valdivieso marci@berkeleylanguageinstitute.com	**8 languages offered**: Arabic, Chinese (Mandarin, Cantonese, and Taishanese/ Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese	Yes	• Professional language assessments for interpreters, translators, & bilingual speakers • Language Proficiency Oral Assessment – ideal for current & pre-employment bilingual employees • Language Proficiency Written Assessment • Medical Staff Oral Assessment • Healthcare Interpreter Assessments	Evaluators are experienced linguists that have: • At least five years interpreter & translator experience • Have shown an aptitude to be language evaluators. • They are generally certified by/with the National Board or CCHI if the language pair is an option, or • They are otherwise assessed and trained prior to being given evaluation assignments	Cost will vary depending on language pair and type of assessment $115 - $190/ person
Culture Advantage Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.	https://cultureadvantage.org/ 1-316-217-0198 Marlene Obermeyer, MA, RN director@cultureadvantage.org	**10 languages offered**: Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese	Yes All medical specialties offered in the professional program	• Bilingual Staff Medical Interpreting Skills Assessment (MISA) • Specialty-specific Medical Interpreting Skills Assessment	• Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair	Cost will vary $200 /MISA $250 - $950 for Online Courses
ISI Language Solutions ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations.	https://isilanguagesolutions.com/industries/healthcare/ 1-818-753-9181 John Lopez john@isitrans.com Christina Xu Christina@isitrans.com	**22 languages offered**: Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese	No	• Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole ○ Language Proficiency Assessment ○ Building Cultural Competency Workshop ○ Medical Terminology Workshop ○ Medical Interpreting Ethics and Protocol Workshop	Professional Linguists • Certification or Accreditation from American Translators Association (ATA) or equivalent organization • Degree in Translation or foreign equivalent • Subject-Matter expertise in the field of Life Sciences • Extensive experience in translation and linguistics	Must contact for costs Cost example: • Flat rate/ test - $80

To report any updates to this document, i.e., an organization that should no longer be included, or an organization that meets the criteria and should be included on this document, please contact: Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Language Line Academy (LLA) Our professional testing and training ensures the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.	https://www.langualeline.com/ 1-844-552-8378 Ana Catalina Arguedas Fernández lla@languageline.com	**1 language offered**: Spanish	Yes Pediatrics Mental Health OB/Gyn Ophthalmology Gastroenterology Oncology Cardiology Pharmacy	• Healthcare Bilingual Fluency assessment for clinicians and medical staff • Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour • Interpreter Readiness Assessment • Interpreter Skills Test	LLA testers have a variety of qualifications, including: • M.A., Translation & Interpretation • Years of medical interpreting experience • External interpreter certification credentials	Cost will vary $145 - $160/ test Volume discounts available
Language Testing International (LTI) In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests.	https://www.languagetesting.com/ 1-800-486-8444 Marketing/ Scheduling Team Diane ext. 123 Dina ext. 127 info@languagetesting.com	**100+ languages offered**, most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish View complete list of languages online	Offers general testing/ proficiency assessments Does not specifically assess proficiency for healthcare interpretation or translation services	• Oral Proficiency Interview 15 – 30 minute telephonic interview • Oral Proficiency Interview – Computer 20 – 40 minute on-demand, internet or phone-delivered proficiency test • Writing Proficiency Test via the web 20 – 80 minutes • Listening Proficiency Test 50 – 125 minutes • Reading Proficiency Test 50 – 125 minutes	LTI strictly uses • Certified ACTFL testers and raters Ensuring quality and validity of tests	Contact for costs Package options available for some languages Cost examples: • $100 - $200/ person for phone survey • $159 for web based proctoring
MasterWord For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.	https://www.masterword.com/ 1-866-716-4999 masterword@masterword.com	**250+ languages offered** for interpreting and translation **Contact for languages offered for proficiency assessments**	Not specified Offers On Demand training & Webinars for Healthcare, includes: • Maternal Fetal Medicine • Cardiology • Mental Health • Oncology • Emergency	• Language Proficiency Assessment: 60 minutes Contact for languages • Health Care Interpreter Assessment (HCIA®): 32 min. / 45 min. –oral / written Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.	Assessments based on formats of CCHI & NBCMI national certification exams	On Demand Assessments: $105 - $155

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Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).

We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials:
email Ivy Diaz at ivy.diaz@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

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24-890/BKT1617350EH04w (9/24)

INJECTABLE MEDICATION HCPCS / DOFR CROSSWALK

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q2055	ABECMA	Idecabtagene vicleucel, suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0287	ABELCET	Amphotericin B lipid complex	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0400	ABILIFY	Aripiprazole, intramuscular, 0.25 mg	THERAPEUTIC INJ	
J0402	ABILIFY ASIMTUFII®	Aripiprazole IM ER Susp Prefilled Syringe	THERAPEUTIC	
J0401	ABILIFY MAINTENA	Apriprazole 300mg, IM injection	THERAPEUTIC INJ	
J9264	ABRAXANE	Paclitaxel protein-bound particles, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5132	ABRILADA™	Injection, adalimumab-afzb , biosimilar, 10 mg- 0069-0347-02; 40mg 0069-0319-01.	THERAPEUTIC INJ	
Q5132	ABRILADA™	Injection, adalimumab-afzb , biosimilar, 20, 40mg - 00069-0333-02; 00069-0325-01; 00069-0325-02; 00069-0328-02; 00025-0325-02 ; 00025-0328-02; 00025-0333-02; 00025-0325-01	SELF-INJECTABLE	
TBD	ABRYSVO™	Respiratory Syncytial Virus Vaccine solution for intramuscular injection	THERAPEUTIC INJ	IMMUNIZATION
J0137	Acetaminophen	Injection, acetaminophen (Hikma) not therapeutically equivalent to J0131, 10 mg	THERAPEUTIC INJ	
J0134	Acetaminophen 10mg/ml solution	Injection, acetaminophen (fresenius kabi) not therapeutically equivalent to j0131, 10 mg	THERAPEUTIC INJ	
J0136	Acetaminophen 10mg/ml solution	Injection, acetaminophen (b braun) not therapeutically equivalent to j0131, 10 mg	THERAPEUTIC INJ	
J1120	ACETAZOLAMIDE SODIUM	Acetazolamide sodium injection	THERAPEUTIC INJ	
J0132	ACETYLCYSTEINE INJ	Acetylcysteine injection, 10 mg	THERAPEUTIC INJ	
J3262	ACTEMRA 162mg/0.9ml Syringe (50242-0138-01)	Tocilizumab, 1 mg	SELF-INJECTABLE	
J3262	ACTEMRA INJECTION (50242-0136-01, 50242-0137-01)	Tocilizumab 200mg, 400mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0802	ACTHAR® HP	Corticotropin injection, 40 MG	THERAPEUTIC INJ	
J0801	ACTHAR® HP	Corticotropin injection, 80 MG	THERAPEUTIC INJ	
90648	ACTHIB	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0795	ACTHREL	Corticorelin Ovine Triflutal	THERAPEUTIC INJ	
J9216	ACTIMMUNE	Interferon gamma 1-b 3 miillion units	SELF-INJECTABLE	CHEMO ADJUNCT*
J2997	ACTIVASE	Alteplase recombinant, 1mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0133	ACYCLOVIR SODIUM	Acyclovir, 5 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90715	ADACEL	Tdap vaccine, > 7 yrs, IM	THERAPEUTIC INJ	IMMUNIZATION
J2504	ADAGEN	Pegademase bovine, 25 IU	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0791	ADAKVEO	Crizanlizumab-tmca IV Solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	ADBRY™	Tralokinumab-ldrm injection, for subcutaneous use	THERAPEUTIC INJ	
J3590	ADBRY™	Tralokinumab-ldrm injection, for subcutaneous use	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

Rev. April 9, 2024

Effective October 7, 2024

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9042	ADCETRIS	Brentuximab vedotin Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0153	ADENOCARD	Adenosine 6 MG	THERAPEUTIC INJ	
C9399, J3490	ADLYXIN	Lixisenatide Solution	SELF-INJECTABLE	
J0171	ADRENALIN	Adrenalin (epinephrine) inject	THERAPEUTIC INJ	
J9000	ADRIAMYCIN	Doxorubicin hcl 10 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9190	ADRUCIL	Fluorouracil injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9029	ADSTILADRIN®	Nadofaragene firadenovec-vncg) suspension, for intravesical use	THERAPEUTIC	CHEMOTHERAPY*
~~J0172~~	~~ADUHELM™~~	~~Aducanumab-avwa IV Solution~~	~~THERAPEUTIC INJ~~	
J7192	ADVATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7207	ADYNOVATE	Antihemophilic Factor (Recombinant), PEGylated, is a human antihemophilic factor	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3590	ADZYNMA	Adamts13 recombinant-krhn	THERAPEUTIC INJ	
90685	AFLURIA® Peds Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90688	AFLURIA® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7210	AFSTYLA	Injection, factor VIII, antihemophilic factor,recombinant	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3246	AGGRASTAT	Tirofiban HCl, 0.25 mg	THERAPEUTIC INJ	
Q2034	AGRIFLU	Influenza virus vaccine, split virus, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1720	A-HYDROCORT	Hydrocortisone sodium succinate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	AIMOVIG	Erenumab-aooe injection, for subcutaneous use	SELF-INJECTABLE	
J3031	AJOVY	Fremanezumab-vfrm	SELF-INJECTABLE	
J0190	AKINETON	Biperiden lactate, per 5 mg	THERAPEUTIC INJ	
J3490	AKOVAZ	Ephedrine sulfate injection, USP for intravenous use	THERAPEUTIC INJ	
J1454	AKYNZEO	Fosnetupitant and palonsetron) for injection, for intravenous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1931	ALDURAZYME	Laronidase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0216	Alfentanil	Alfentanil HCl injection	THERAPEUTIC INJ	
J9215	ALFERON N	Interferon alfa-N3 (human leukocyte derived), 250,000 IU inj	SELF-INJECTABLE	CHEMO ADJUNCT*
J9305	ALIMTA	Pemetrexed, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9057	ALIQOPA	Copanlisib for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9245	ALKERAN	Melphalan hydrochl 50 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0206	Allopurinol	Injection, allopurinol sodium, 1 mg	THERAPEUTIC INJ	
J2469	ALOXI	Palonosetron HCl, 25 mcg	THERAPEUTIC INJ	CHEMO ADJUNCT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7190	ALPHANATE	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7186	ALPHANATE VWF	Von Willebrand Factor complex, human, ristocetin coFactor (not otherwise specified), per I.U.	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7193	ALPHANINE SD	Factor IX (antihemophilic Factor, purified, non-recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7201	ALPROLIX	Coagulation Factor IX (Recombinant), Fc Fusion Protein], Lyophilized Powder for Solution for Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0270	Alprostadil 500	Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct physician supervision, not for use when drug is self-administered)	SELF-INJECTABLE	
J7214	ALTUVIIIO™	Antihemophilic factor (recombinant) DNA-derived, Factor VIII concentrate, lyophilized powder for solution, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
Q1256	ALYMSYS®	Bevacizumab-maly injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0289	AMBISOME	Amphotericin B liposome inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2920	A-METHAPRED	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	A-METHAPRED	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0215	AMEVIVE	Alefacept	THERAPEUTIC INJ	
S0017	AMICAR	Aminocaproic acid	THERAPEUTIC INJ	
J0278	AMIKACIN SULF INJ USP 1GRAM/4ML FLIPTOP VIAL	Amikacin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0278	AMIKIN	Amikacin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0280	AMINOPHYLLINE	Aminophyllin 250 MG inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0282	AMIODARONE HCL	Amiodarone hcl	THERAPEUTIC INJ	
C9399, J3490	AMJEVITA	Adalimumab-atto injection for subcutaneous use	SELF-INJECTABLE	
J1426	AMONDYS 45™	Casimersen injection, for intravenous use	THERAPEUTIC INJ	
J3470	AMPHADASE 150 UNIT/ML SOLN	Hyaluronidase, up to 150 units	THERAPEUTIC INJ	
J0285	AMPHOCIN	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0288	AMPHOTEC	Ampho b cholesteryl sulfate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0285	AMPHOTERICIN B	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0290	AMPICILLIN SODIUM	Ampicillin 500 MG inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0295	AMPICILLIN-SULBACTAM	Ampicillin sodium per 1.5 gm	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	AMTAGVI™	Lifileucel IV Susp 72,000,000,000 Cells	THERAPEUTIC INJ	CHEMOTHERAPY
J0225	AMVUTTRA™	Vutrisiran injection, for subcutaneous use	THERAPEUTIC INJ	
J0300	AMYTAL SODIUM	Amobarbital 125 MG inj	THERAPEUTIC INJ	
J0716	ANASCORP	Centruroides immune f(ab)2, up to 120 milligrams	THERAPEUTIC INJ	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

INJECTABLE MEDICATION HCPCS / DOFR CROSSWALK

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0690	ANCEF	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7169	ANDEXXA	Coagulation factor Xa (recombinant), inactivated-zhzo) Lyophilized Powder for Solution For Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0330	ANECTINE	Succinycholine chloride inj	THERAPEUTIC INJ	
J0583	ANGIOMAX	Bivalirudin, 1mg	THERAPEUTIC INJ	
J1738	ANJESO	Meloxicam injection, for intravenous use	THERAPEUTIC INJ	
90581	ANTHRAX VACCINE	Anthrax vaccine, sc	THERAPEUTIC INJ	IMMUNIZATION
J1451	ANTIZOL	Fomepizole, 15 mg	THERAPEUTIC INJ	
J1260	ANZEMET	Dolasetron mesylate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2277	APHEXDA™	Motixafortide for injection, for subcutaneous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0364	APOKYN	Apomorphine hydrochloride, 1mg	SELF-INJECTABLE	
C9145	APONVIE™	Injection, aprepitant, 1 mg	THERAPEUTIC	
J0739	APRETUDE™	Cabotegravir extended-release injectable suspension), for intramuscular use	THERAPEUTIC INJ	
J3430	AQUA-MEPHYTON	Vitamin K phytonadione inj	THERAPEUTIC INJ	
J0256	ARALAST	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0390	ARALEN	Chloroquine injection	THERAPEUTIC INJ	
J0380	ARAMINE	Metaraminol bitartrate	THERAPEUTIC INJ	
J0881	ARANESP	Darbepoetin alfa, 1 microgram (non-ESRD use)	SELF-INJECTABLE	CHEMO ADJUNCT*
J0882	ARANESP	Darbepoetin alfa, 1 microgram (for ESRD on dialysis	SELF-INJECTABLE	CHEMO ADJUNCT*
J2793	ARCALYST	Rilonacept Injection 220 mg Solr	SELF-INJECTABLE	
90679	AREXVY	Respiratory Syncytial Virus Vaccine, Adjuvanted	THERAPEUTIC INJ	IMMUNIZATION
J0883	ARGATROBAN	Injection, argatroban, 1 mg (for non-ESRD use)	THERAPEUTIC INJ	
J0884	ARGATROBAN	Injection, argatroban, 1 mg (for ESRD on dialysis)	THERAPEUTIC INJ	
J0891	ARGATROBAN	Injection, argatroban (accord), not therapeutically equivalent to j0883, 1 mg (for non-esrd use)	THERAPEUTIC INJ	
J0892	ARGATROBAN	Injection, argatroban (accord), not therapeutically equivalent to j0884, 1 mg (for esrd on dialysis)	THERAPEUTIC INJ	
J0898	ARGATROBAN	Injection, argatroban (AuroMedics), not therapeutically equivalent to J0883, 1 mg (for non-ESRD use)	THERAPEUTIC INJ	
J0899	ARGATROBAN	Injection, argatroban (AuroMedics), not therapeutically equivalent to J0884, 1 mg (for ESRD on dialysis)	THERAPEUTIC INJ	
J1944	ARISTADA	Aripprazole lauroxilextended release suspension	THERAPEUTIC INJ	
J1943	ARISTADA INITIO	Aripiprazole lauroxil extended-release injectable suspension	THERAPEUTIC INJ	
J3302	ARISTOCORT FORTE	Triamcinolone diacetate inj	THERAPEUTIC INJ	
J3303	ARISTOSPAN INTRA-ARTICULAR	Triamcinolone hexacetonl inj	THERAPEUTIC INJ	
J3303	ARISTOSPAN INTRALESIONAL	Triamcinolone hexacetonl inj	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1652	ARIXTRA	Fondaparinux sodium, 0.5 mg	SELF-INJECTABLE	
J9261	ARRANON 5 MG/ML SOLN	Nelarabine, 50 Mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0391	ARTESUNATE	Artesunate 110MG Solution Reconstituted	THERAPEUTIC INJ	
J9302	ARZERRA	Ofatumumab	THERAPEUTIC INJ	CHEMOTHERAPY*
J1554	ASCENIV	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid),	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399, J3490	ASCLERA	Polidocanol Injection	THERAPEUTIC INJ	
J9118	ASPARLAS	Calaspargase pegol-mknl, 10 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J2275	ASTRAMORPH	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7504	ATGAM	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2060	ATIVAN	Lorazepam injection	THERAPEUTIC INJ	
J0461	ATROPINE SULFATE	Atropine sulfate injection	THERAPEUTIC INJ	
90705	ATTENUVAX	Measles vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
C9257	AVASTIN	Bevacizumab, 0.25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9035	AVASTIN	Bevacizumab injection, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3145	AVEED	Testosterone undecanoate 250 mg/ml	THERAPEUTIC INJ	
J2280	AVELOX	Moxifloxacin 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1826	AVONEX	Interferon beta-1A, 11 mcg for intramuscular use (See also J1825)	SELF-INJECTABLE	
Q3027	AVONEX	Interferon beta-1a, 33 mcg	SELF-INJECTABLE	
Q5121	AVSOLA	Injection, infliximab-axxq, biosimilar, 10mg	THERAPEUTIC INJ	
J0714	AVYCAZ	Ceftazidime-avibactam Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0073	AZACTAM	Aztreonam, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7501	AZATHIOPRINE SODIUM	Azathioprine parenteral	THERAPEUTIC INJ	TRANSPLANT*
J0457	Aztreonam	Injection, aztreonam, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0475	BACLOFEN	Baclofen 10 MG injection	THERAPEUTIC INJ	
J2700	BACTOCILL IN DEXTROSE	Oxacillin sodium injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0470	BAL IN OIL	Dimecaprol injection	THERAPEUTIC INJ	
J1412	BALFAXAR®	Injection, prothrombin complex concentrate (human), per IU of Factor IX activity	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0184	BARHEMSYS	Amisulpride (antiemetic) IV soln 10 mg/4ml	THERAPEUTIC INJ	
J9023	BAVENCIO	Avelumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
C9462	BAXDELA	Delafloxacin for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0222	BEBTELOVIMAB	BEBTELOVIMAB IV SOLN 175 MG/2ML	THERAPEUTIC INJ	
J7194	BEBULIN VH	Factor IX, complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9032	BELEODAQ	Belinostat Injection	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9036	BELRAPZO	Bendamustine hydrochloride injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1200	BENADRYL	Diphenhydramine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9058	Bendamustine	Injection, bendamustine HCl (Apotex), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9059	Bendamustine	Injection, bendamustine HCl (Baxter), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9034	BENDEKA	Bendamustine HCl Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7195	BENEFIX	Factor IX (antihemophilic Factor, recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0490	BENLYSTA	Belimumab 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	BENLYSTA SubQ INJ	Belimumab subcutaneous solution auto-injector	SELF-INJECTABLE	
J0500	BENTYL	Dicyclomine injection	THERAPEUTIC INJ	
J0179	BEOVU	Brolucizumab-dbll, 1 mg Injection	THERAPEUTIC INJ	
J0597	BERINERT	C1 Esterase Inhibitor (Human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9229	BESPONSA	Inotuzumab ozogamicin for IV soln	THERAPEUTIC INJ	CHEMOTHERAPY*
C9999	BESREMi®	Ropeginterferon alfa-2b-njft) injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1830	BETASERON	Interferon beta-1b / .25 MG	SELF-INJECTABLE	
90620	BEXSERO	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90381	BEYFORTUS™	Nirsevimab-alip IM Soln Prefilled Syringe 100 MG/ML	THERAPEUTIC INJ	
90380	BEYFORTUS™	Nirsevimab-alip IM Soln Prefilled Syringe 50 MG/ML	THERAPEUTIC INJ	
J0558	BICILLIN C-R (25000)	Penicillin G benzathine and penicillin G procaine, 25,000U	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Penicillin G benzathine, up to 600,000 units	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Penicillin G benzathine, up to 1,200,000 units	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Penicillin G benzathine, up to 2,400,000 units	THERAPEUTIC INJ	
J9050	BICNU	Carmustine, 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	BIMZELX®	Bimekizumab-bkzx	SELF-INJECTABLE	
J1556	BIVIGAM	Immune Globulin Intravenous (Human), 10% liquid	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9040	BLENOXANE	Bleomycin sulfate injection, 15 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9037	BLENREP	Belantamab mafodotin-blmf for iv soln 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9040	BLEOMYCIN SULFATE	Bleomycin sulfate injection, 15 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9039	BLINCYTO	Blinatumomab for Injection, IV	THERAPEUTIC INJ	CHEMOTHERAPY*
J1740	BONIVA	Ibandronate sodium Injection, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90715	BOOSTRIX	Tdap vaccine	THERAPEUTIC INJ	IMMUNIZATION
J9046	Bortezomib	Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9048	Bortezomib	Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9049	Bortezomib	Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9051	Bortezomib	Inj, bortezomib (maia)	THERAPEUTIC INJ	CHEMOTHERAPY*
J0585	BOTOX	OnabotulinumtoxinA, 1 unit	THERAPEUTIC INJ	
90287	BOTULINIM ANTITOXIN	Botulinim antitoxin, equine, any route	THERAPEUTIC INJ	
90288	BOTULISM	Botulism immune globulin, human, IV	THERAPEUTIC INJ	
J3355	BRAVELLE	Urofollitropin, 75 iu	SELF-INJECTABLE	INFERTILITY
J3105	BRETHINE	Terbutaline sulfate inj	THERAPEUTIC INJ	
Q2054	BREYANZI	Lisocabtagene maraleucel suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0567	BRINEURA	Cerliponase alfa for intraventricular use	THERAPEUTIC INJ	
J2329	BRIUMVI™	Ublituximab-xiiy	THERAPEUTIC	
C9399, J3490	BRIVIACT	Brivaracetam injection, for intravenous use, CV-	THERAPEUTIC INJ	
J0576	BRIXADI™	Buprenorphine extended release subcutaneous injection	THERAPEUTIC INJ	
J0945	BROMPHENIRAMINE MALEATE	Brompheniramine maleate inj	THERAPEUTIC INJ	
J1939	BUMETANIDE	Injection, bumetanide, 0.5 mg	THERAPEUTIC INJ	
S0020	Bupivicaine	Bupivicaine hydro	THERAPEUTIC INJ	
J0665	Bupivicaine	Injection, bupivicaine, not otherwise specified, 0.5 mg	THERAPEUTIC INJ	
J0592	BUPRENEX	Buprenorphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0594	BUSULFEX 6MG/ML	Busulfan injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0595	BUTORPHANOL TARTRATE	Butorphanol tartrate 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	BYDUREON	Exenatide extended release	SELF-INJECTABLE	
J3490	BYDUREON BCise	Exenatide extended release injectable suspension 2 mg	SELF-INJECTABLE	
J3490	BYETTA	Exenatide Injection	SELF-INJECTABLE	
J2249	BYFAVO®	Injection, remimazolam, 1 mg	THERAPEUTIC INJ	
Q5124	BYOOVIZ	Ranibizumab-nuna Intravitreal Injection	THERAPEUTIC INJ	
J0741	CABENUV	CABOTEGRAVIR & RILPIVIRINE	THERAPEUTIC INJ	HIV/AIDS
C9047	CABLIVI	Caplacizumab-yhdp	SELF-INJECTABLE	
J0706	CAFCIT	Caffeine citrate injection, 5 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0636	CALCIJEX	Calcitriol per 0.1 mcg	THERAPEUTIC INJ	
S0161	CALCITROL	Calcitrol, 0.25 mg	THERAPEUTIC INJ	
J0600	CALCIUM DISODIUM VERSENATE	Edetate calcium disodium inj	THERAPEUTIC INJ	
J0610	CALCIUM GLUCONATE	Calcium gluconate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0612	Calcium gluconate	Injection, calcium gluconate (Fresenius Kabi), per 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0613	Calcium gluconate	Injection, calcium gluconate (WG Critical Care), per 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0611	Calcium gluconate	Injection, calcium gluconate (wg critical care), per 10 ml	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1741	CALDOLOR	Injection, ibuprofen, 100 mg	THERAPEUTIC INJ	
J0620	CALPHOSAN	Calcium glycer & lact/10 ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1952	CAMCEVI	Leuprolide injectable, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9010	CAMPATH	Alemtuzumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9206	CAMPTOSAR	Irinotecan injection, 20mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0637	CANCIDAS	Caspofungin acetate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0670	CARBOCAINE	Mepivacaine HCL/10 ml	THERAPEUTIC INJ	
J9045	CARBOPLATIN	Carboplatin injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1566	CARIMUNE NF	Immune globulin, intravenous, lyophilized (eg powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9052	Carmustine	Injection, carmustine (Accord), not therapeutically equivalent to J9050, 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1955	CARNITOR	Levocarnitine per 1 gm	THERAPEUTIC INJ	
Q2056	CARVYKTI	Ciltacabtagene autoleucel suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	CASGEVY™	Exagamglogene autotemcel, suspension for intravenous infusion	THERAPEUTIC INJ	
J2997	CATHFLO ACTIVASE	Alteplase recombinant, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0270	CAVERJECT	Alprostadil for injection	SELF-INJECTABLE	
J0710	CEFADYL	Cephapirin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0688	CEFAZOLIN	Injection, cefazolin sodium (Hikma), not therapeutically equivalent to J0690, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0690	CEFAZOLIN SODIUM	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0689	Cefazolin sodium	Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0701	Cefepime	Injection, cefepime HCl (Baxter), not therapeutically equivalent to Maxipime, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0703	Cefepime	Injection, cefepime HCl (B. Braun), not therapeutically equivalent to Maxipime, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0783	Cefepime	Cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg J0703 Injection	THERAPEUTIC INJ	
J0715	CEFIZOX	Ceftizoxime sodium / 500 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0715	CEFIZOX IN D5W	Ceftizoxime sodium / 500 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0021	CEFOPERAZONE	Cefoperazone sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0698	CEFOTAXIME SODIUM	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0074	CEFOTETAN	Cefotetan disodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0694	CEFOXITIN SODIUM	Cefoxitin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0713	CEFTAZIDIME	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0697	CEFUROXIME SODIUM	njection, sterile cefuroxime sodium, per 750 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0697	CEFUROXIME-DEXTROSE	Sterile cefuroxime injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0702	CELESTONE SOLUSPAN	Betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7599	CELLCEPT 500MG	Immunosuppressive drug, not otherwise classified	THERAPEUTIC INJ	TRANSPLANT*
J1890	CEPHALOTHIN SODIUM	Cephalothin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2724	CEPROTIN	Protein C concentrate, intravenous, human, 10 IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0713	CEPTAZ	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2009	CEREBYX	Fosphenytoin, 50 mg phenytoin equivalent	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0205	CEREDASE	Alglucerase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1786	CEREZYME	Imiglucerase, per unit	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9150	CERUBIDINE	Daunorubicin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90650	CERVARIX	Human Papillomavirus Bivalent (Types 16 and 18) Vaccine, Recombinant	THERAPEUTIC INJ	IMMUNIZATION
J3490	CETROTIDE	Cetrorelix acetate for inj kit 0.25 mg	SELF-INJECTABLE	INFERTILITY
J0720	CHLORAMPHENICOL SOD SUCCINATE	Chloramphenicol sodium inject	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0720	CHLOROMYCETIN	Chloramphenicol sodium inject	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2401	Chloroprocaine	Chloroprocaine hydrochloride, per 1 mg	THERAPEUTIC INJ	
J3230	CHLORPROMAZINE HCL	Chlorpromazine hcl injection	THERAPEUTIC INJ	
90725	CHOLERA VACCINE	Cholera vaccine, injectable	THERAPEUTIC INJ	IMMUNIZATION
J0725	CHORIONIC GONADOTROPIN	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
Q5128	CIMERLI™	Injection, ranibizumab-eqrn , biosimilar, 0.1 mg	THERAPEUTIC INJ	
J0717	CIMZIA® Prefilled Syr KIT 200MG NDC 50474-710-81; 50474-710-79	Certolizumab, 200 mg/mL solution in a single-dose prefilled syringe	SELF-INJECTABLE	
J0717	CIMZIA® Vial NDC 50474-700-62	Certolizumab, 200 mg lyophilized powder in a single-dose vial	THERAPEUTIC INJ	
J2786	CINQAIR	Reslizumab	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0598	CINRYZE	Injection, C-1 esterase inhibitor (human), 10 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0185	CINVANTI	Aprepitant, Injection, 1 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0744	CIPRO	Ciprofloxacin for intravenous infusion, 200 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0744	CIPRO IN D5W	Ciprofloxacin for intravenous infusion, 200 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9060	CISPLATIN	Cisplatin 10 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9060	CISPLATIN	Cisplatin 50 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9065	CLADRIBINE	Cladribine per 1 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0698	CLAFORAN	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0698	CLAFORAN IN D5W	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0077	CLEOCIN	Clindamycin phosphate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9248	CLEVIPREX	Clevidipine butyrate, 1 mg	THERAPEUTIC INJ	
J0736	Clindamycin	Injection, clindamycin phosphate, 300 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0737	Clindamycin	Injection, clindamycin phosphate (Baxter), not therapeutically equivalent to J0736, 300 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9027	CLOLAR	Clofarabine injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J2402	CLOROTEKAL®	Chloroprocaine hydrochloride injection, for intrathecal use	THERAPEUTIC INJ	
J7175	COAGADEX	Injection, factor X, (human), 1 IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0745	CODEINE PHOSPHATE	Codeine phosphate /30 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0515	COGENTIN	Benztropine mesylate, 1 mg	THERAPEUTIC INJ	
J0760	COLCHICINE	Colchicine injection	THERAPEUTIC INJ	
J0770	COLISTIMETHATE SODIUM	Colistimethate sodium inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9286	COLUMVI™	Glofitamab-gxbm injection for intravenous (IV) infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0770	COLY-MYCIN M	Colistimethate sodium inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0780	COMPAZINE	Prochlorperazine, up to 10 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1595	COPAXONE	Glatiramer acetate	SELF-INJECTABLE	
J0282	CORDARONE IV	Amiodarone hcl	THERAPEUTIC INJ	
J7180	CORIFACT	Factor XIII Concentrate	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0834	CORTROSYN	Cosyntropin per 0.25 MG	THERAPEUTIC INJ	
J1742	CORVERT	Ibutilide fumarate injection	THERAPEUTIC INJ	
J1448	COSELA	Trilaciclib for injection, for intravenous	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	COSENTYX	Secukinumab Injection	SELF-INJECTABLE	
J3590	COSENTYX® IV	Secukinumab IV Soln 125 Mg/5ml	THERAPEUTIC INJ	
J3590	COSENTYX® UNOREADY®	Secukinumab Subcutaneous Soln Auto-Injector 300 Mg/2ml	SELF-INJECTABLE	
J9120	COSMEGEN	Dactinomycin, 0.5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0834	Cosyntropin 0.25 MG (generic)	Cosyntropin, not otherwise specified, 0.25 mg	THERAPEUTIC INJ	
J2650	COTOLONE	Prednisolone acetate inj	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1833	CRESEMBA	Isavuconazonium sulfate Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0840	CROFAB	Injection, crotalidae polyvalent immune fab (Ovine), up to 1 gram	THERAPEUTIC INJ	
J0584	CRYSVITA	Burosumab-twza injection, for subcutaneous use	THERAPEUTIC INJ	
J0878	CUBICIN	Daptomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	CUROSURF	Poractant alfa intratracheal suspension	THERAPEUTIC INJ	
J1551	CUTAQUIG	Immune Globulin Subcutaneous (Human) - hipp	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1555	CUVITRU	Immune Globulin Subcutaneous 20% Solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3420	CYANOCOBALAMIN	Vitamin B-12 cyanocobalamin, up to 1000mcg	THERAPEUTIC INJ	
J9070	CYCLOPHOSPHAMIDE	Cyclophosphamide 100 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9080	CYCLOPHOSPHAMIDE	Cyclophosphamide 200 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9090	CYCLOPHOSPHAMIDE	Cyclophosphamide 500 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9091	CYCLOPHOSPHAMIDE	Cyclophosphamide 1.0 grm inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9092	CYCLOPHOSPHAMIDE	Cyclophosphamide 2.0 grm inj	THERAPEUTIC INJ	CHEMOTHERAPY*
C9087	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (AuroMedics), 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9072	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (Dr. Reddy's), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9074	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (sandoz), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7516	CYCLOSPORINE	Cyclosporine, parenteral, 250mg	THERAPEUTIC INJ	TRANSPLANT*
J3590	CYLTEZO	Adalimumab-adbm injection, for subcutaneous use	SELF-INJECTABLE	
J9308	CYRAMZA	Ramucirumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9100	CYTARABINE	Cytarabine hcl 100 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9110	CYTARABINE	Cytarabine, 500mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90291	CYTOGAM	Injection, cytomegalovirus, immune globulin intravenous (human), CMV-IgIV intravenous, human, per vial	THERAPEUTIC INJ	
J0850	CYTOGAM	Injection, cytomegalovirus, immune globulin intravenous (human), CMV-IgIV intravenous, human, per vial	THERAPEUTIC INJ	
J1570	CYTOVENE	Ganciclovir sodium injection	THERAPEUTIC INJ	HIV/AIDS
J9070	CYTOXAN	Cyclophosphamide 100 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9080	CYTOXAN	Cyclophosphamide 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9090	CYTOXAN	Cyclophosphamide 500 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9091	CYTOXAN	Cyclophosphamide 1.0 grm injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9092	CYTOXAN	Cyclophosphamide 2.0 grm injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1110	D.H.E. 45	Dihydroergotamine mesyltate	SELF-INJECTABLE	
J9130	DACARBAZINE	Dacarbazine 100 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9140	DACARBAZINE	Dacarbazine 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0894	DACOGEN	Decitabine for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0875	DALVANCE	Dalbavancin hcl for iv soln 500 mg	THERAPEUTIC INJ	
J9348	DANYELZA	Naxitamab-gqgk 40MG/10ML Solution Injection, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90700	DAPTACEL	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J0878	Daptomycin	Injection, daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0877	Daptomycin	Daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0874	DAPTOMYCIN	Inj, daptomycin (baxter), not therapeutically equivalent to J0878	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0873	DAPTOMYCIN	Injection, daptomycin, not therapeutically equivalent to J0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9145	DARZALEX	Daratumumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9144	DARZALEX FASPRO	Injection, daratumumab 10 mg and hyaluronidase-fihj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9150	DAUNORUBICIN HCL	Daunorubicin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9151	DAUNOXOME	Daunorubicin citrate liposomal formulation, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0589	DAXXIFY	DaxibotulinumtoxinA-lanm for injection, for intramuscular use	THERAPEUTIC INJ	
J2597	DDAVP	Desmopressin acetate, per 1 mcg	THERAPEUTIC INJ	
90714	DECAVAC	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0893	Decitabine	Injection, decitabine (Sun Pharma) not therapeutically equivalent to J0894, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0895	DEFEROXAMINE MESYLATE	Deferoxamine mesylate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	DEFITELIO	Defibrotide sodium injection, for intravenous use	THERAPEUTIC INJ	
J1100	DEKASOL	Dexamethasone sodium phosphate 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	DEKASOL LA	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3265	DEMADEX	Torsemide 10 mg/ml	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2175	DEMEROL	Meperidine hydrochlide /100 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9098	DEPOCYT	Cytarabine liposome, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1000	DEPO-ESTRADIOL	Depo-estradiol cypionate injection	THERAPEUTIC INJ	
J1020	DEPO-MEDROL 20	Methylprednisolone 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	DEPO-MEDROL 40	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1040	DEPO-MEDROL 80	Methylprednisolone 80 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	DEPO-PROVERA 150 MG	Medroxyprogesterone contraceptive injection	THERAPEUTIC INJ	
J1053	DEPO-PROVERA 400 MG	Medroxyprogesterone injection 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3490	DEPO-SUBQ PROVERA 104	Medroxyprogesterone acetate Injection	THERAPEUTIC INJ	
J1071	DEPO-TESTOSTERONE	Testosterone cypionate, 1mg	THERAPEUTIC INJ	TRANSGENDER HORMONES
J0895	DESFERAL	Deferoxamine mesylate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2597	DESMOPRESSIN ACETATE	Desmopressin acetate	THERAPEUTIC INJ	
J1094	DEXAMETHASONE ACETATE	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1100	DEXAMETHASONE SODIUM PHOSPHATE	Dexamethasone sodium phosphate 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1100	DEXAMETHASONE SODIUM PHOSPHATE	Dexamethasone sodium phos	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	DEXASONE L.A.	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1750	DEXFERRUM	Iron dextran, 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1190	DEXRAZOXANE	Dexrazoxane hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
C9048	DEXTENZA	Dexamethasone Ophthalmic Insert.	THERAPEUTIC INJ	
J7100	DEXTRAN 40 IN D5W	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	DEXTRAN 40 IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7110	DEXTRAN 75 IN D5W	Dextran 75 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7110	DEXTRAN 75 IN NACL	Dextran 75 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7060	DEXTROSE	5% Dextrose/water	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7070	DEXTROSE	Infusion, D5W, 1000 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7121	DEXTROSE in LACTATED RINGERS 5%	5% dextrose in lactated ringer's, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S5010	DEXTROSE-NaCL 5 – 0.45% SOLUTION	5% dextrose and 0.45% normal saline, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9034	DEXYCU	Dexamethasone intraocular suspension	THERAPEUTIC INJ	
J3360	DIAZEPAM	Diazepam, up to 5 mg	THERAPEUTIC INJ	
J0500	DICYCLOMINE HCL	Dicyclomine injection	THERAPEUTIC INJ	
J1450	DIFLUCAN IN SODIUM CHLORIDE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1162	DIGIBIND	Digoxin immune fab (ovine)	THERAPEUTIC INJ	
J1162	DIGIFAB	Digoxin immune fab (ovine)	THERAPEUTIC INJ	
J1160	DIGOXIN	Digoxin injection	THERAPEUTIC INJ	
J1110	DIHYDROERGOTAMINE MESYLATE	Dihydroergotamine mesyltate	SELF-INJECTABLE	
J1170	DILAUDID	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0092	DILAUDID	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1180	DILOR	Dyphylline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1240	DIMENHYDRINATE	Dimenhydrinate injection	THERAPEUTIC INJ	
J1200	DIPHENHYDRAMINE HCL	Diphenhydramine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
90719	DIPHTHERIA TOXOID	Diphtheria toxoid, IM	THERAPEUTIC INJ	IMMUNIZATION
90702	DIPHTHERIA-TETANUS TOXOIDS	DT vaccine < 7 yrs, IM	THERAPEUTIC INJ	IMMUNIZATION
90718	DIPHTHERIA-TETANUS TOXOIDS	Td vaccine > 7, IM	THERAPEUTIC INJ	IMMUNIZATION
J2704	DIPRIVAN	Propofol, 10 mg	THERAPEUTIC INJ	
90296	DIPTHERIA ANTITOXIN	Diptheria antitoxin, equine any route	THERAPEUTIC INJ	
J1245	DIPYRIDAMOLE INJECTION	Dipyridamole injection	THERAPEUTIC INJ	
J1205	DIURIL IV	Chlorothiazide sodium, per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1250	DOBUTAMINE HCL	Dobutamine HCL 250 mg	THERAPEUTIC INJ	
J9172	Docetaxel	Injection, docetaxel (Ingenus), not therapeutically equivalent to J9171, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1265	DOPAMINE HCL	Dopamine hcl, 40 mg injection	THERAPEUTIC INJ	
J1265	DOPAMINE HCL 200MG IN 5% DEXTROSE	Dopamine injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1265	DOPAMINE HCL 800MG IN 5% DEXTROSE	Dopamine injection	THERAPEUTIC INJ	
J1265	DOPAMINE IN D5W	Dopamine injection	THERAPEUTIC INJ	
J1267	DORIBAX	Doripenem, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1267	DORIBAX	Doripenem, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2050	DOXIL	Doxorubicin hydrochloride, liposomal, Doxil, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1790	DROPERIDOL	Droperidol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1810	DROPERIDOL/FENTANYL CITRATE	Droperidol/fentanyl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90723	DTAP-HEP B-IPV VACCINE	Dtap-Hep B-Ipv Vaccine, IM	THERAPEUTIC INJ	IMMUNIZATION
J9130	DTIC-DOME	Dacarbazine 100 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9130	DTIC-DOME	Dacarbazine 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590, C9399	DUPIXENT	Dupilumab injection, for subcutaneous use	SELF-INJECTABLE	
J0735	DURACLON	Clonidine hydrochloride	THERAPEUTIC INJ	
J2270	DURAMORPH	Morphine sulfate, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2274	DURAMORPH	Morphine sulfate, preservative-free for epidural or intrathecal use, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	DURAMORPH	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7318	DUROLANE	Sodium hyaluronic, for single intra-articular injection 60mg/3ml	THERAPEUTIC INJ	
J7351	DURYSTA	Injection, bimatoprost, intracameral implant, 1 microgram	THERAPEUTIC INJ	
J1130	DYLOJECT	Diclofenac sodium, 0.5 mg, Injection	THERAPEUTIC INJ	
J0586	DYSPORT	AbobotulinumtoxinA, 5 units	THERAPEUTIC INJ	
J3520	EDETATE DISODIUM	Edetate disodium /150 mg	THERAPEUTIC INJ	
J0270	EDEX	Injection, alprostadil, 1.25 mcg	SELF-INJECTABLE	
J3590, C9399	EGRIFTA SV	Tesamorelin acetate for inj 2 mg	SELF-INJECTABLE	HIV/AIDS
J9063	ELAHERE	Injection, mirvetuximab soravtansine-gynx, 1 mg , for intravenous use	THERAPEUTIC	CHEMOTHERAPY*
J1743	ELAPRASE	Idursulfase,1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1743	ELAPRASE	Idursulfase,1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1320	ELAVIL	Amitriptyline injection	THERAPEUTIC INJ	
J3060	ELELYSO	Taliglucerase alfa Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1413	ELEVIDYS	Delandistrogene moxeparvovec-rokl suspension, for intravenous infusion	THERAPEUTIC INJ	
J2508	ELFABRIO	Pegunigalsidase alfa-iwxj injection	THERAPEUTIC INJ	
J9217	ELIGARD	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	ELIGARD	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J2783	ELITEK	Rasburicase, 0.5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9178	ELLENCE	Epirubicin hcl, 2 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9175	ELLIOTTS B	Elliotts b solution per ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J7205	ELOCTATE	Antihemophilic Factor (Recombinant), Fc Fussion Protein], Lyophilized Powder for Solution For Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9263	ELOXATIN	Oxaliplatin	THERAPEUTIC INJ	CHEMOTHERAPY*
J1323	ELREXFIO™	Injection, elranatamab-bcmm, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY
J9020	ELSPAR	Asparaginase injection, 10,000 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9269	ELZONRIS	Tagraxofusp-erzs injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1453	EMEND 115 MG SOLR	Fosaprepitant, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	EMGALITY	Galcanezumab-gnlm	SELF-INJECTABLE	
J0350	EMINASE	Anistreplase 30 u	THERAPEUTIC INJ	
C9151	EMPAVELI™	Pegcetacoplan subcutaneous Solution 1080 mg/20ml	THERAPEUTIC INJ	
J9176	EMPLICITI	Elotuzumab for Intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J1438	ENBREL	Etanercept injection	SELF-INJECTABLE	
90740	ENGERIX-B	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90746	ENGERIX-B	Hepatitis B vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90744	ENGERIX-B 10 MCG/0.5ML INJ	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90747	ENGERIX-B 20 MCG/ML INJ	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9358	ENHERTU	Fam-trastuzumab deruxtecan-nxki for IV Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J1302	ENJAYMO™	Sutimlimab-jome) injection, for intravenous use	THERAPEUTIC INJ	
J3590	ENSPRYNG™	Satralizumab-mwge for subcutaneous use	SELF-INJECTABLE	
J3380	ENTYVIO	Vedolizumab for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3380	ENTYVIO® (SubQ)	Vedolizumab soln **pen-injector** 108 MG/0.68ML 64764-0108-20; 64764-0108-21	SELF-INJECTABLE	
J3490	EPHEDRINE	Ephedrine sulfate inj 50 mg/ml	THERAPEUTIC INJ	
J0173	Epinephrine	Injection, epinephrine (belcher) not therapeutically equivalent to j0171, 0.1 mg	THERAPEUTIC INJ	
J0171	EPINEPHRINE HCL	Adrenalin epinephrine inject	THERAPEUTIC INJ	
J3490	EPIPEN	Epinephrine hcl injection device 1:1000	SELF-INJECTABLE	
J3490	EPIPEN JR	Epinephrine hcl injection device 1:1000	SELF-INJECTABLE	
J9231	EPKINLY™	Epcoritamab-bysp injection for subcutaneous (SC) use.	THERAPEUTIC INJ	CHEMOTHERAPY*
J0885	EPOGEN	Epoetin alfa, (for non-ESRD use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
Q4081	EPOGEN	Epoetin Alfa, 100 Units (For ESRD On Dialysis) (For Renal Dialysis Facilities And Hospital Use)	SELF-INJECTABLE	
J0348	ERAXIS 50 MG	Anadulafungin injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9055	ERBITUX	Cetuximab injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	ERELZI	Etanercept-szzs injection, for subcutaneous	SELF-INJECTABLE	
J1330	ERGONOVINE MALEATE	Ergonovine maleate injection	THERAPEUTIC INJ	
J9019	ERWINAZE	Asparaginase Erwinia chrysanthemi Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1364	ERYTHROCIN	Erythromycin lactobionate 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1364	ERYTHROMYCIN LACTOBIONATE	Erythromycin lactobionate 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1805	Esmolol	Injection, esmolol HCl, 10 mg	THERAPEUTIC INJ	
J1806	Esmolol	Injection, esmolol HCl (WG Critical Care) not therapeutically equivalent to J1805, 10 mg	THERAPEUTIC INJ	
J7204	ESPEROCT	Antihemophilic factor (recombinant), glycopegylated-exei is a coagulation Factor VIII concentrate indicated for use in adults and children with hemophilia A	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1380	ESTRADIOL VALERATE 10 MG/ML	Estradiol valerate injection, Up to 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
J1430	ETHAMOLIN	Ethanolamine oleate 100 mg	THERAPEUTIC INJ	
J0207	ETHYOL	Amifostine	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9181	ETOPOPHOS	Etoposide 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7323	EUFLEXXA	Sodium Hyaluronate injection	THERAPEUTIC INJ	
J3111	EVENITY	Romosozumab-aqqg injection, for subcutaneous use	THERAPEUTIC INJ	
J1305	EVKEEZA	Evinacumab-dgnb injection, for intravenous	THERAPEUTIC INJ	
J9246	EVOMELA	Melphalan	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	EVUSHELD™	Tixagevimab 150 Mg/1.5ml & Cilgavimab 150 Mg/1.5ml IM Soln	THERAPEUTIC INJ	
C9399/J3490	EVZIO	Naloxone hydrochloride injection Auto-Injector	SELF-INJECTABLE	
J1428	EXONDYS 51	Eteplirsen IV Soln 100 MG/2ML	THERAPEUTIC INJ	
C9290	EXPAREL	Injection, bupivacaine liposome, 1 mg	THERAPEUTIC INJ	
J1830	EXTAVIA	Interferon beta-1b	SELF-INJECTABLE	
J0178	EYLEA	Aflibercept injection	THERAPEUTIC INJ	
J0177	EYLEA® HD	Aflibercept Injection 8 MG	THERAPEUTIC INJ	
J0180	FABRAZYME	Agalsidase beta injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0517	FASENRA	Benralizumab, for subcutaneous use	THERAPEUTIC INJ	
J0517	FASENRA PEN	Benralizumab subcutaneous soln auto-injector 30 mg/ml	SELF-INJECTABLE	
J9395	FASLODEX	Fulvestrant	THERAPEUTIC INJ	CHEMOTHERAPY*
J7198	FEIBA VH IMMUNO (ANTI-INHIBITOR COAGULANT COMPLEX)	Anti-inhibitor, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1951	FENSOLVI	Leuprolide acetate for injectable suspension,	THERAPEUTIC INJ	
J3010	FENTANYL CITRATE	Fentanyl citrate injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1810	FENTANYL-DROPERIDOL	Droperidol/fentanyl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q0138	FERAHEME INJECTION	Ferumoxytol 1 mg, for iron deefiency anemia, non-ESRD use	THERAPEUTIC INJ	
Q0139	FERAHEME INJECTION	Ferumoxytol 1 mg, for iron deefiency anemia, for ESRD on dialysis	THERAPEUTIC INJ	
J2916	FERRLECIT	Na ferric gluconate complex	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0699	FETROJA®	Injection, cefiderocol, 10 mg	THERAPEUTIC INJ	
J0693	FETROJA®	Injection, cefiderocol, 5 mg	THERAPEUTIC INJ	
J7177	FIBRYGA	Fibrinogen Concentrate (Human) Lyophilized Powder for Reconstitution	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1744	FIRAZYR	Icatibant	SELF-INJECTABLE	
J9155	FIRMAGON	Degarelix, 1 mg for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
S0030	FLAGYL	Metronidazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1572	FLEBOGAMMA	Immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1325	FLOLAN	Epoprostenol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0155	FLOLAN STREILE DILUENT	Sterile diluent for epoprostenol, 50 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0034	FLOXIN	Ofloxacin, 400 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9200	FLOXURIDINE	Floxuridine injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90694	FLUAD® Quadrivalent	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90686	FLUARIX® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90682	FLUBLOK® QUAD INJ 2022-23	nfluenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90674	FLUCELVAX® QUADRIVALENT 2022-2023	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1450	FLUCONAZOLE IN DEXTROSE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1450	FLUCONAZOLE IN SODIUM CHLORIDE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9185	FLUDARA	Fludarabine phosphate injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9185	FLUDARABINE PHOSPHATE	Fludarabine phosphate injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90686	FLULAVAL® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9190	FLUOROURACIL	Fluorouracil injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2679	FLUPHENAZINE	Injection, fluphenazine HCl, 1.25 mg	THERAPEUTIC INJ	
J2680	FLUPHENAZINE DECANOATE	Fluphenazine decanoate 25 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q2037	FLUVIRIN	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90662	FLUZONE® High-Dose Quadrivalent	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular	THERAPEUTIC INJ	IMMUNIZATION
90685	FLUZONE® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90688	FLUZONE® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90687	FLUZONE® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1434	FOCINVEZ	Injection, fosaprepitant, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
S0128	FOLLISTIM AQ	Follitropin beta, 75 IU	SELF-INJECTABLE	INFERTILITY
J9307	FOLOTYN	Pralatrexate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0713	FORTAZ	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0713	FORTAZ IN D5W	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3110	FORTEO	Teriparatide, 10 mcg	SELF-INJECTABLE	
J1456	Fosaprepitant	Injection, fosaprepitant (Teva), not therapeutically equivalent to J1453, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1455	FOSCAVIR	Foscarnet sodium injection	THERAPEUTIC INJ	HIV/AIDS
J1645	FRAGMIN	Dalteparin sodium, per 2,500 IU	SELF-INJECTABLE	
J9200	FUDR	Floxuridine injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5108	FULPHILA	Pegfilgrastim-jmdb biosimilar	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5108	FULPHILA	Pegfilgrastim-jmdb, biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J9393	FULVESTRANT	Injection, fulvestrant (Teva) not therapeutically equivalent to J9395, 25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9394	FULVESTRANT	Injection, fulvestrant (Fresenius Kabi) not therapeutically equivalent to J9395, 25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9395	FULVESTRANT	Fulvestrant inj, 25 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0285	FUNGIZONE	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1941	FUROSCIX	Injection, furosemide 20 mg	THERAPEUTIC INJ	
J1940	FUROSEMIDE	Furosemide injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0641	FUSILEV	Levoleucovorin calcium, 0.5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1324	FUZEON	Enfuvirtide, 1 mg	SELF-INJECTABLE	HIV/AIDS
J9331	FYARRO	Sirolimus protein-bound particles for IV	THERAPEUTIC INJ	CHEMOTHERAPY*
Q1530	FYLNETRA	Pegfilgrastim-pbbk injection, for subcutaneous use	THERAPEUTIC INJ	
J0475	GABLOFEN	Baclofen inj	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1560	GAMA**STAN** 15-18%	Gamma globulin, intramuscular, over 10 cc (always use for any amount injected over 10cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	GAMA**STAN** 1 cc	Gamma globulin, intramuscular, 1 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9210	GAMIFANT	Emapalumab-lzsg injection, for intravenous use	THERAPEUTIC INJ	
J1569	GAMMAGARD LIQUID	Immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1566	GAMMAGARD S/D	Immune globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561	GAMMAKED	Injection, immune globulin, intravenous, non-lyophilized, e.g. liquid	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1557	GAMMAPLEX	Immune Globulin Intravenous (human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561	GAMUNEX-C	Immune globulin, (Gamunex/Gamunex-C/Gammaked	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561-JB	GAMUNEX-C	Immune Globulin Injection (human) 10% Caprylate/chromatography purified - Subcutaneous	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1574	Ganciclovir	Injection, ganciclovir sodium (Exela) not therapeutically equivalent to J1570, 500 mg	THERAPEUTIC INJ	HIV/AIDS
S0132	GANIRELIX	Ganirelix acetate 250 mcg	SELF-INJECTABLE	INFERTILITY
J1457	GANITE	Gallium nitrate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
90649	GARDASIL	Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (Gardasil is only indicated in males and females from 9 through 26 years of age)	THERAPEUTIC INJ	IMMUNIZATION
90651	GARDASIL 9	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use (Gardasil 9 is only indicated for females from 9 through 26 years of age and males from 9 through 15 years of age)	THERAPEUTIC INJ	IMMUNIZATION
J3490/C9399	GATTEX 5 MG KIT	Teduglutide [rDNA origin], for Injection, for subcutaneous use	SELF-INJECTABLE	
J9301	GAZYVA	Obinutuzumab Injection 10 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J7326	GEL-ONE	Hyaluronan or derivative, Gel-One, for intra-articular injection	THERAPEUTIC INJ	
J7328	GEL-SYN	Hyaluronan or derivative for intra-articular injection, 0.1 mg	THERAPEUTIC INJ	
J9196	Gemcitabine	Injection, gemcitabine hydrochloride (Accord), not therapeutically equivalent to J9201, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9201	GEMZAR	Gemcitabine HCl, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0395	GENESA	Arbutamine hcl injection	THERAPEUTIC INJ	
J2941	GENOTROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J1580	GENTAMICIN SULFATE	Gentamicin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	GENTRAN 40 IN D5W	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	GENTRAN 40 IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7320	GENVISC 850	Hyaluronan or derivative, for intra-articular injection	THERAPEUTIC INJ	
J3486	GEODON	Ziprasidone mesylate	THERAPEUTIC INJ	
J3490	GIAPREZA	Angiotensin II Injection for Intravenous Infusion	THERAPEUTIC INJ	
J0223	GIVLAARI	Givosiran injection, for Subcutaneous use	THERAPEUTIC INJ	
J0257	GLASSIA	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1595	GLATOPA	Glatiramer acetate, 20 mg	SELF-INJECTABLE	
J1610	GLUCAGEN	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1610	GLUCAGON	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1611	GLUCAGON	Injection, glucagon HCl (Fresenius Kabi), not therapeutically equivalent to J1610, per 1 mg	SELF-INJECTABLE	
J1610	GLUCAGON EMERGENCY	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1596	Glycopyrrolate	Injection, glycopyrrolate, 0.1 mg	THERAPEUTIC INJ	
J1600	GOLD SODIUM THIOMALATE	Gold sodium thiomaleate injection	THERAPEUTIC INJ	
S0126	GONAL-F	Follitropin alfa 75 iu	SELF-INJECTABLE	INFERTILITY
J1447	GRANIX	tbo-filgrastim, 1 microgram	SELF-INJECTABLE	CHEMO ADJUNCT*
J1447	GRANIX	tbo-filgrastim, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J1610	GVOKE	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J0599	HAEGARDA	C1 esterase inhibitor (human) for subcutaneous inj	SELF-INJECTABLE	
J9179	HALAVEN	Eribulin mesylate Injecton	THERAPEUTIC INJ	CHEMOTHERAPY*
J1630	HALDOL	Haloperidol injection	THERAPEUTIC INJ	
J1631	HALDOL DECANOATE	Haloperidol decanoate injection	THERAPEUTIC INJ	
J1630	HALOPERIDOL LACTATE	Haloperidol injection	THERAPEUTIC INJ	
90632	HAVRIX	Hepatitis A vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90633	HAVRIX	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90371	H-BIG	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
J1270	HECTOROL	Doxercalciferol	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7192	HELIXATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1411	HEMGENIX®	Etranacogene dezaparvovec-drlb) suspension, for intravenous infusion	THERAPEUTIC INJ	
J7170	HEMLIBRA	Emicizumab-kxwh injection, for subcutaneous use	SELF-INJECTABLE	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7190	HEMOFIL M	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90748	HEP B/HIB VACCINE	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use (Price is per 0.5 mL dose)	THERAPEUTIC INJ	IMMUNIZATION
J1642	HEP FLUSH-10	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1571	HEPAGAM B - IM	Hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 mL (see J1573 for IV use)	THERAPEUTIC INJ	
J1573	HEPAGAM B - IV	Hepatitis B immune globulin (Hepagam B), intravenous, 0.5 mL (see J1571 for IM use)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1643	HEPARIN	Injection, heparin sodium (Pfizer), not therapeutically equivalent to J1644, per 1000 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN (PORCINE) IN D5W	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN (PORCINE) IN NACL	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN (PORCINE) IN NACL	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN (PORCINE) LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN COMBINATION	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM (BOVINE)	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM (PORCINE)	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN SODIUM FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM IN NACL	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN SODIUM LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90739	HEPLISAV-B	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1642	HEP-LOCK	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEP-LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEP-LOCK PF	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9355	HERCEPTIN	Trastuzumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9355	HERCEPTIN HYLECTA™	Trastuzumab, excludes biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5113	HERZUMA	Trastuzumab-pkrb, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90646	HIB VACCINE, PRP-D	Hib Vaccine, Prp-D, IM	THERAPEUTIC INJ	IMMUNIZATION
90648	HIBERIX	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1559	HIZENTRA	Immune Globulin Subcutanenous (human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90281	HUMAN IG, IM	Immune Globulin (IG), human, for intramuscular use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90283	HUMAN IG, IV	Immune Globulin (IGIV), human, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90284	HUMAN IG, SUB Q	Immune globulin (IGIV), human, for use in subcutaneous infusions, 100 mg, each	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7187	HUMATE-P	Von Willebrand Factor complex, human, ristocetin coFactor, per IU, VWF:RCO	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2941	HUMATROPE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J0135	HUMIRA	Adalimumab injection	SELF-INJECTABLE	
J7321	HYALGAN	Hyaluronan or derivative,for intra-articular injection, per dose	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9351	HYCAMTIN	Topotecan, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0360	HYDRALAZINE HCL	Hydralazine hcl injection	THERAPEUTIC INJ	
J1700	HYDROCORTISONE ACETATE	Hydrocortisone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1710	HYDROCORTONE	Hydrocortisone sodium ph injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1170	HYDROMORPHONE HCL	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3425	HYDROXO-COBOLAMINE	Injection, hydroxocobalamin, 10 mcg	THERAPEUTIC INJ	
J1729	HYDROXYprogesterone Caproate	HYDROXYprogesterone Caproate 1.25 GM/5ML SOLN	THERAPEUTIC INJ	
J3410	HYDROXYZINE HCL	Hydroxyzine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3473	HYLENEX	Hyaluronidase, recombinant, 1 USP unit	THERAPEUTIC INJ	
J7322	HYMOVIS	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
90375	HYPERRAB	Rabies Immune Globulin (RIg), human, for intramuscular and/or subcutaneous use	THERAPEUTIC INJ	
J1730	HYPERSTAT	Diazoxide injection	THERAPEUTIC INJ	
J1575	HYQVIA 10 GM/100ML KIT	Immune Globulin Infusion 10% [human] with recombinant human hyaluronidase	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5131	IDACIO®	Adalimumab-aacf	SELF-INJECTABLE	
J9211	IDAMYCIN PFS	Idarubicin hcl injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9211	IDARUBICIN	Idarubicin hcl injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7202	IDELVION	Coagulation Factor IX (Recombinant), Albumin Fusion Protein (rIX-FP), a recombinant human blood coagulation factor	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9208	IFEX	Ifosfomide injection, 1 gram	THERAPEUTIC INJ	CHEMOTHERAPY*
J9208	IFOSFAMIDE	Ifosfomide injection, 1 gram	THERAPEUTIC INJ	CHEMOTHERAPY*
J2403	IHEEZO™	Chloroprocaine Hcl Ophth Gel 3%	THERAPEUTIC INJ	
J0638	ILARIS INJECTION	Canakinumab 180 mg	THERAPEUTIC INJ	
J3245	ILUMYA	Tildrakizumab-asmn 100 mg/ml injection, for subcutaneous use	THERAPEUTIC INJ	
J7313	ILUVIEN	fluocinolone acetonide, intravitreal implant, 0.01 mg	THERAPEUTIC INJ	
J3490	IMCIVREE	Setmelanotide injection, for subcutaneous use	SELF-INJECTABLE	
J9173	IMFINZI	Durvalumab soln for IV infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3030	IMITREX	Sumatriptan, succinate	SELF-INJECTABLE	
J3030	IMITREX STATDOSE	Sumatriptan, succinate	SELF-INJECTABLE	
J9347	IMJUDO®	Tremelimumab-actl soln for IV infusion 25 mg/1.25ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9325	IMLYGIC	Talimogene laherparepvec, 1 million plaque forming units (PFU)	THERAPEUTIC INJ	CHEMOTHERAPY*
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 2cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 3cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 4cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 5cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 6cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 7cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 8cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 9cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 10cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1560	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, over 10cc (always use for any amount injected over 10cc and place number of units)(1cc = 1 unit)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90376	IMOGAM RABIES-HT	Rabies IG, heat treated	THERAPEUTIC INJ	
90675	IMOVAX RABIES	Rabies vaccine, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7307	IMPLANON	Etonogestrel (Contraceptive) Implant System, Including Implants And Supplies	THERAPEUTIC INJ	
J7501	IMURAN	Azathioprine parenteral	THERAPEUTIC INJ	TRANSPLANT*
J1790	INAPSINE	Droperidol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2170	INCRELEX	Mecasermin [rDNA origin] Injection	SELF-INJECTABLE	GROWTH HORMONE
J1800	INDERAL	Propranolol injection	THERAPEUTIC INJ	
90700	INFANRIX	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J1750	INFED	Iron dextran 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5103	INFLECTRA	Infliximab, biosimilar, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90654	INFLUENZA VACCINE	Influenza virus vaccine, split virus, preservative free, for intradermal use	THERAPEUTIC INJ	IMMUNIZATION
J9198	INFUGEM	Gemcitabine in sodium chloride injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2270	INFUMORPH 200	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2271	INFUMORPH 200	Morphine SO4 injection 100mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	INFUMORPH 200	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	INFUMORPH 500	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1439	INJECTAFER	Ferric carboxymaltose Injection	THERAPEUTIC INJ	
J1815	INSULIN	Injection, insulin, per 5 units	PHARMACY BENEFIT	
J1327	INTEGRILIN	Eptifibatide injection	THERAPEUTIC INJ	
J9214	INTRON-A	Interferon alfa-2b, recombinant, 1 million units	SELF-INJECTABLE	CHEMOTHERAPY*
J1335	INVANZ	Ertapenem injection, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2426	INVEGA HAFYERA™	Paliperidone palmitate inj, 1 MG	THERAPEUTIC INJ	
J2426	INVEGA SUSTENNA	Paliperidone palmitate	THERAPEUTIC INJ	
J3490	INVEGA TRINZA	Paliperidone palmitate extended release injectable	THERAPEUTIC INJ	
90713	IPOL	Poliovirus Vaccine Inactivated	THERAPEUTIC INJ	IMMUNIZATION
J1750	IRON DEXTRAN COMPLEX	Iron dextran, 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9315	ISTODAX	Romidepsin, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9207	IXEMPRA KIT	Ixabepilone, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90738	IXIARO SUSPENSION	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5109	IXIFI	Infliximab-qbtx, biosimilar, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7213	IXINITY	Coagulation factor IX (recombinant)] Lyophilized Powder for Solution for Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2782	IZERVAY	Avacincaptad Pegol Intravitreal Soln 2 MG/0.1ML (20 MG/ML)	THERAPEUTIC INJ	
J9281	JELMYTO	Mitomycin pyelocalyceal instillation, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9272	JEMPERLI	Dostarlimab-gxly	THERAPEUTIC INJ	CHEMOTHERAPY*
J7316	JETREA	Ocriplasmin Intravitreal Injection, 2.5 mg/mL	THERAPEUTIC INJ	
90735	JE-VAX	Japanese Encephalitis Virus Vaccine Inactivated	THERAPEUTIC INJ	IMMUNIZATION
J9043	JEVTANA	Cabazitaxel Injection 60 MG/1.5ML SOLN	THERAPEUTIC INJ	CHEMOTHERAPY*
J7208	JIVI	Antihemophilic factor (recombinant), PEGylated-aucl] lyophilized powder for solution, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9354	KADCYLA	Ado-trastuzumab emtansine for iv soln 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1290	KALBITOR	Ecallantide	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1840	KANAMYCIN SULFATE	Kanamycin sulfate 500 MG injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1850	KANAMYCIN SULFATE	Kanamycin sulfate 75 MG injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5117	KANJINTI	Trastuzumab-anns,10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2480	KANUMA	Sebelipase alfa injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7168	KCENTRA	Prothrombin Complex Concentrate (Human)) for Intravenous Use	THERAPEUTIC INJ	
90399	KEDRAB	Rabies Immune Globulin (RIg), human, for intramuscular use	THERAPEUTIC INJ	
J0690	KEFZOL	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3301	KENALOG	Triamcinolone acetonide injection, 10 mg	THERAPEUTIC INJ	
C9460	KENGREAL	Cangrelor Injection	THERAPEUTIC INJ	
J2425	KEPIVANCE	Palifermin injectionection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1953	KEPPRA	Levetiracetam, 500 mg/5 mL injection	THERAPEUTIC INJ	
J1953	KEPPRA 500 MG/5ML SOLN	Levetiracetam, 10 mg	THERAPEUTIC INJ	
J3590	KESIMPTA	Ofatumumab soln auto-injector 20 mg/0.4ml	SELF-INJECTABLE	
J3490	KETAMINE	Ketamine hcl Injection	THERAPEUTIC INJ	
J1885	KETOROLAC TROMETHAMINE	Ketorolac tromethamine injection	THERAPEUTIC INJ	
J3590	KEVZARA	Sarilumab subcutaneous soln prefilled syringe	SELF-INJECTABLE	
J9271	KEYTRUDA	Pembrolizumab for injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0642	KHAPZORY	Levoleucovorin for IV soln	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9274	KIMMTRAK®	Tebentafusp-tebn IV soln 100 mcg/0.5m	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2046	KIMYRSA™	Oritavancin Diphosphate For IV Soln 1200 Mg	THERAPEUTIC INJ	
J3590	KINERET	Anakinra subcutaneous injection 100 mg/0.67ml	SELF-INJECTABLE	
90696	KINRIX SUSP	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7190	KOATE-DVI	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7192	KOGENATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0879	KORSUVA™	Difelikefalin injection, for intravenous use	THERAPEUTIC INJ	
J7211	KOVALTRY	Antihemophilic Factor (Recombinant), is a recombinant,human DNA sequence derived, full length Factor VIII concentrate	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2507	KRYSTEXXA	Pegloticase	THERAPEUTIC INJ	
C9399, J3490	KYBELLA	Deoxycholic Acid injection	THERAPEUTIC INJ	
Q2042	KYMRIAH	Tisagenlecleucel, up to 250 million car-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J9047	KYPROLIS	Carfilzomib Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1626	KYTRIL	Granisetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
S0091	KYTRIL	Granisetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1920	Labetalol	Injection, labetalol HCl, 5 mg	THERAPEUTIC INJ	
J1921	Labetalol	Injection, labetalol HCl (Hikma) not therapeutically equivalent to J1820, 5 mg	THERAPEUTIC INJ	
J7120	LACTATED RINGER'S	Ringers lactate infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0217	LAMZEDE	Velmanase alfa-tycv) for injection, for intravenous use	THERAPEUTIC INJ	
J1160	LANOXIN	Digoxin injection	THERAPEUTIC INJ	
J1932	Lanreotide 1 mg (Cipla)	Lanreotide acetate, 1 mg	THERAPEUTIC INJ	
J9285	LARTRUVO	Injection, olaratumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0202	LEMTRADA	Alemtuzumab Injection for Intravenous Infusion	THERAPEUTIC INJ	
J0174	LEQEMBI™	Lecanemab-irmb injection, for intravenous use	THERAPEUTIC INJ	
J1306	LEQVIO®	Inclisiran injection, for subcutaneous use	THERAPEUTIC INJ	
J0640	LEUCOVORIN CALCIUM	Leucovorin calcium injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2820	LEUKINE	Sargramostim injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9218	LEUPROLIDE ACETATE	Leuprolide acetate injection	SELF-INJECTABLE	CHEMOTHERAPY*
J9065	LEUSTATIN	Cladribine per 1 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J1956	LEVAQUIN	Levofloxacin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1955	LEVOCARNITINE	Levocarnitine per 1 gm	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1960	LEVO-DROMORAN	Levorphanol tartrate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	Levothyroxine Injection, 200 mcg	Levothyroxine	THERAPEUTIC INJ	
J3490	Levothyroxine Injection, 500 mcg	Levothyroxine	THERAPEUTIC INJ	
J1980	LEVSIN	Hyoscyamine sulfate injection	THERAPEUTIC INJ	
J1990	LIBRIUM	Chlordiazepoxide injection	THERAPEUTIC INJ	
J9119	LIBTAYO	Cemiplimab-Rwlc IV Soln	THERAPEUTIC INJ	CHEMOTHERAPY*
J2001	LIDOCAINE IN D5W	Lidocaine injection	THERAPEUTIC INJ	
J2010	LINCOCIN	Lincomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2021	LINEZOLID	Injection, linezolid (Hospira) not therapeutically equivalent to J2020, 200 mg	THERAPEUTIC INJ	
J0476	LIORESAL	Baclofen intrathecal	THERAPEUTIC INJ	
J7100	LMD IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9999	LOQTORZI™	Toripalimab-tpzi IV solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J2060	LORAZEPAM	Lorazepam injection	THERAPEUTIC INJ	
J1650	LOVENOX	Enoxaparin sodium, 10 mg	SELF-INJECTABLE	
J2778	LUCENTIS 0.5 MG/0.05ML SOLN	Ranibizumab, 0.5 Mg	THERAPEUTIC INJ	
J2560	LUMINAL	Phenobarbital sodium injection	THERAPEUTIC INJ	
J0221	LUMIZYME	Alglucosidase alfa	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9313	LUMOXITI	Moxetumomab pasudotox-tdfk for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9350	LUNSUMIO™	Mosunetuzumab-axgb) injection, for intravenous use	THERAPEUTIC	CHEMOTHERAPY*
C9399, J3490	LUPANETA PACK	Leuprolide acetate for depot suspension; norethindrone acetate tablets	THERAPEUTIC INJ	
J9218	LUPRON	Leuprolide acetate injection Kit 5 mg	SELF-INJECTABLE	CHEMOTHERAPY*
J1950	LUPRON DEPOT	Leuprolide acetate 3.75 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	LUPRON DEPOT	Leuprolide acetate suspension 7.5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	LUPRON DEPOT-PED	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	LUSEDRA	Fospropofol disodium Injection	THERAPEUTIC INJ	
A9513	LUTATHERA	Lutetium Lu 177 dotatate injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1954	LUTRATE DEPOT®	Injection, leuprolide acetate for depot suspension, 7.5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	LUVERIS	Lutropin alfa for subcutaneous injection 75 unit	SELF-INJECTABLE	INFERTILITY
J3398	LUXTURNA	Voretigene neparvovec-rzyl	THERAPEUTIC INJ	
J3590	LYFGENIA®	Lovotibeglogene autotemcel suspension for intravenous infusion	THERAPEUTIC INJ	
90665	LYME DISEASE VACCINE	Lyme disease vaccine, adult dosage, IM	THERAPEUTIC INJ	IMMUNIZATION
J2503	MACUGEN	Pegaptanib sodium, 0.3 mg	THERAPEUTIC INJ	
J3475	MAGNESIUM SULFATE	Magnesium sulfate	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2150	MANNITOL	Mannitol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9353	MARGENZA	Injection, margetuximab-cmkb, 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0692	MAXIPIME	Cefepime hcl for injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90708	MEASLES-RUBELLA VACCINE	Measles-Rubella Vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J1051	MEDROXYPROGESTERONE MICRO	Medroxyprogesterone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0694	MEFOXIN IN DEXTROSE	Cefoxitin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9249	Melphalan Hydrochloride	Injection, melphalan (apotex), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90734	MENACTRA	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90644	MENHIBRIX	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90733	MENOMUNE	Meningococcal Polysaccharide Vaccine, Groups A, C, Y and W-135 Combined	THERAPEUTIC INJ	IMMUNIZATION
S0122	MENOPUR	Menotropins 75 iu	SELF-INJECTABLE	INFERTILITY
90619	MENQUADFI™	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90734	MENVEO	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J2180	MEPERGAN	Meperidine/promethazine injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2175	MEPERIDINE HCL	Meperidine hydrochl /100 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3397	MEPSEVII™	Vestronidase alpha-vjbk	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2184	MEROPENEM	Injection, meropenem (B. Braun) not therapeutically equivalent to J2185, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2185	MERREM	Meropenem 100MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90706	MERUVAX II	Rubella vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9209	MESNA	Mesna injection, 200mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9209	MESNEX	Mesna injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1230	METHADONE HCL	Methadone HCl, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2210	METHERGINE	Methylergonovin maleate injection	THERAPEUTIC INJ	
J2800	METHOCARBAMOL	Methocarbamol injection	THERAPEUTIC INJ	
J9255	METHOTREXATE	Injection, methotrexate (Accord), not therapeutically equivalent to J9250 and J9260, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9260	METHOTREXATE POWDER 1GM IN 50ML SD VIAL (P.F.)	Methotrexate sodium injection, 25mg/ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE POWDER 1GM IN 50ML SD VIAL (P.F.)	Methotrexate sodium injection, 25mg/ml (Not for Chemotherapy)	SELF-INJECTABLE	
J9250	METHOTREXATE SODIUM	Methotrexate sodium injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE SODIUM	Methotrexate sodium injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9250	METHOTREXATE SODIUM LPF	Methotrexate sodium injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0210	METHYLDOPATE HCL	Methyldopate hcl injection	THERAPEUTIC INJ	
J1020	METHYLPRED 20	Methylprednisolone 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	METHYLPRED 40	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1040	METHYLPREDNISOLONE ACETATE	Methylprednisolone 80 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	METHYLPREDNISOLONE ACETATE USP	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J2920	METHYLPREDNISOLONE SODIUM SUCC	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	METHYLPREDNISOLONE SODIUM SUCC	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2765	METOCLOPRAMIDE HCL	Metoclopramide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1836	Metronidazole	Injection, metronidazole, 10 mg	THERAPEUTIC INJ	
J0630	MIACALCIN	Calcitonin salmon injection	SELF-INJECTABLE	
J2247	MICAFUNGIN	Injection, micafungin sodium (Par Pharm) not therapeutically equivalent to J2248, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90385	MICRHOGAM	Rh IG, minidose, IM	THERAPEUTIC INJ	
J2788	MICRHOGAM	Rho d immune globulin, human, minidose, 50 mcg (250 IU)	THERAPEUTIC INJ	
J2251	MIDAZOLAM	Injection, midazolam HCl (WG Critical Care) not therapeutically equivalent to J2250, per 1 mg	THERAPEUTIC INJ	
J2250	MIDAZOLAM HCL	Midazolam hydrochloride	THERAPEUTIC INJ	
J2260	MILRINONE IN DEXTROSE	Milrinone lactate Per 5 MG	THERAPEUTIC INJ	
J2260	MILRINONE LACTATE	Milrinone lactate Per 5 MG	THERAPEUTIC INJ	
J2265	MINOCIN	Minocycline hydrochloride Injection 1 mg	THERAPEUTIC INJ	
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	SELF-INJECTABLE	
J0888	MIRCERA	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	SELF-INJECTABLE	CHEMO ADJUNCT*
J9270	MITHRACIN	Plicamycin, 2.5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MITOMYCIN	Mitomycin 5 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9291	MITOMYCIN	Mitomycin 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
90707	M-M-R II	MMR vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9349	MONJUVI	Tafasitamab-cxix For IV Soln 200 MG	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7190	MONOCLATE-P	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1437	MONOFERRIC	Injection ferric derisomaltose 10 mg	THERAPEUTIC INJ	
J7193	MONONINE	Factor IX (antihemophilic Factor, purified, non-recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7327	MONOVISC	High Molecular Weight Hyaluronan	THERAPEUTIC INJ	
J2270	MORPHINE SULFATE	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2271	MORPHINE SULFATE	Morphine SO4 injection 100mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2274	MORPHINE SULFATE	Morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2272	MORPHINE SULFATE	Injection, morphine sulfate (Fresenius Kabi) not therapeutically equivalent to J2270, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	MORPHINE SULFATE (PF)	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	MOUNJARO™	Tirzepatide Injection, for subcutaneous use	SELF-INJECTABLE	
J2281	MOXIFLOXACIN	Injection, moxifloxacin (Fresenius Kabi) not therapeutically equivalent to J2280, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2562	MOZOBIL 24 MG/1.2ML SOLN	Plerixafor injection	THERAPEUTIC INJ	
90704	MUMPSVAX	Mumps vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9230	MUSTARGEN	Mechlorethamine hydrochloride, (nitrogen mustard), 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MUTAMYCIN	Mitomycin 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MUTAMYCIN	Mitomycin 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5107	MVASI	Bevacizumab-awwb	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	MYALEPT	Metreleptin for injection	SELF-INJECTABLE	
J2248	MYCAMINE	Micafungin sodium for Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9203	MYLOTARG	Gemtuzumab ozogamicin, 0.1 mg 4.5 MG SOLR	THERAPEUTIC INJ	CHEMOTHERAPY*
J0587	MYOBLOC	RimabotulinumtoxinB, 100 units	THERAPEUTIC INJ	
J1600	MYOCHRYSINE	Gold sodium thiomaleate injection	THERAPEUTIC INJ	
J0220	MYOZYME 10 MG	Alglucosidase Alfa, 10 Mg	THERAPEUTIC INJ	
90371	NABI-HB	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
S0032	NAFCILLIN	Nafcillin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1458	NAGLAZYME 1MG/ML	Galsulfase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2300	NALBUPHINE HCL	Nalbuphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	NALMEFENE	Nalmefene hcl inj 1 mg/ml	THERAPEUTIC INJ	
J2322	NANDROLONE DECANOATE	Nandrolone decanoate 200 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2795	NAROPIN	Ropivacaine hcl injection	THERAPEUTIC INJ	
C9399, J3590	NATPARA	Parathyroid Hormone	SELF-INJECTABLE	
J9390	NAVELBINE	Vinorelbine tartrate, per 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2515	NEMBUTAL	Pentobarbital sodium inj, 50 mg	THERAPEUTIC INJ	
J2710	NEOSTIGMINE METHYLSULFATE	Neostigmine methylslate injection	THERAPEUTIC INJ	
J2370	NEO-SYNEPHRINE	Phenylephrine hcl injection	THERAPEUTIC INJ	
J2506	NEULASTA ONPRO KIT	6 mg/0.6 mL Pegfilgrastim in a single-dose prefilled syringe co-packaged with the on-body injector (OBI)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2506	NEULASTA®	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Self-Injectable)	SELF-INJECTABLE	CHEMO ADJUNCT*
J2506	NEULASTA®	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Therapeutic Inj)	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J1442	NEUPOGEN	Filgrastim 300 mcg injection	SELF-INJECTABLE	CHEMO ADJUNCT*
J1442	NEUPOGEN	Filgrastim 480 mcg injection	SELF-INJECTABLE	CHEMO ADJUNCT*
J1442	NEUPOGEN	Filgrastim (G-CSF), excludes biosimilars, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J3420	NEURO B-12 FORTE S	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3420	NEURO B-12 S	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3305	NEUTREXIN	Trimetrexate glucoronate	THERAPEUTIC INJ	
J3490	NEXIUM I.V. 20 MG SOLR	Esomeprazole injection	THERAPEUTIC INJ	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies	THERAPEUTIC INJ	
J0283	NEXTERONE®	Injection, amiodarone hydrochloride, 30 mg	THERAPEUTIC INJ	
J0219	NEXVIAZYME™	Avalglucosidase alfa-ngpt	THERAPEUTIC INJ	
J0219	NEXVIAZYME™	Avalglucosidase alfa-ngpt	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	NGENLA™	Somatrogon-ghla injection, for subcutaneous use	SELF-INJECTABLE	
J2404	Nicardipine	Injection, nicardipine, 0.1 mg	THERAPEUTIC INJ	
J9268	NIPENT	Pentostatin, per 10mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2305	Nitroglycerin	Injection, nitroglycerin, 5 mg	THERAPEUTIC INJ	
Q5110	NIVESTYM	Filgrastim-aafi soln prefilled syringe 300 mcg or 480mcg	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5110	NIVESTYM	Filgrastim-aafi, biosimilar, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J2941	NORDITROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2360	NORFLEX	Orphenadrine injection	THERAPEUTIC INJ	
90371	NOVAPLUS NABI-HB	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
J0725	NOVAREL	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J7182	NOVOEIGHT	Factor VIII, antihemophilic factor, recombinant per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7189	NOVOSEVEN	Factor VIIa (antihemophilic Factor, recombinant), per 1 microgram	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
C9399, J3490	NOXAFIL	Posaconazole Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2796	NPLATE	Romiplostim, 10 micrograms	THERAPEUTIC INJ	
J2300	NUBAIN	Nalbuphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2182	NUCALA	Mepolizumab for injection	THERAPEUTIC INJ	
J2182	NUCALA AUT0-INJECTOR	Injection, mepolizumab, 1 mg Auto-injector 00173-0892-01	SELF-INJECTABLE	
J3490	NULIBRY	Fosdenopterin	THERAPEUTIC INJ	
J0485	NULOJIX	Belatacept, 1 mg injection	THERAPEUTIC INJ	TRANSPLANT*
C9143	NUMBRINO™	Cocaine hydrochloride nasal solution , 1 mg		
J2410	NUMORPHAN	Oxymorphone hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2941	NUTROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2941	NUTROPIN AQ	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2941	NUTROPIN DEPOT	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J7209	NUWIQ	Factor VIII (antihemophilic factor, recombinant) 1 I.U.	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0121	NUZYRA	Omadacycline for injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5122	NYVEPRIA	Pegfilgrastim-apgf	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5122	NYVEPRIA™	Pegfilgrastim-apgf	SELF-INJECTABLE	CHEMO ADJUNCT*
J7188	OBIZUR	Antihemophilic Factor (Recombinant), Porcine Sequence IV Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2350	OCREVUS	Ocrelizumab injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1568	OCTAGAM	Immune Globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0131	OFIRMEV	Acetaminophen Injection	THERAPEUTIC INJ	
Q5114	OGIVRI	Trastuzumab-dkst, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
C9101	OLINVYK	Oliceridine injection, for intravenous use	THERAPEUTIC INJ	
J3490	OMIDRIA	Phenylephrine and ketorolac injection 1% / 0.3%	THERAPEUTIC INJ	
J3590	OMISIRGE®	Omidubicel-onlv Suspension for IV Infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J2941	OMNITROPE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J3590	OMVOH™	Mirikizumab-mrkz I**ntravenous** injection 00002-7575-01	THERAPEUTIC INJ	
J3590	OMVOH™ SubQ	Mirikizumab-mrkz **subcutaneous** injection 00002-8011-01; 00002-8011-27	SELF-INJECTABLE	
J9266	ONCASPAR	Pegaspargase, per single dose vial	THERAPEUTIC INJ	CHEMOTHERAPY*
J9205	ONIVYDE	Irinotecan liposome injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0222	ONPATTRO	Patisiran lipid complex injection, for intravenous use	THERAPEUTIC INJ	
J9160	ONTAK	Denileukin diftitox, 300 mcg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5112	ONTRUZANT	Trastuzumab-dttb, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9299	OPDIVO	Nivolumab, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9298	OPDUALAG™	Nivolumab and relatlimab-rmbw) injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2407	ORBACTIV	Oritavancin diphosphate for IV soln 400 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0129	ORENCIA 125mg/ml Sb-Q (00003-2188-11)	Abatacept subcutaneous inj 125 mg/1ml	SELF-INJECTABLE	
J0129	ORENCIA IV	Abatacept, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2360	ORPHENADRINE CITRATE	Orphenadrine injection	THERAPEUTIC INJ	
J7505	ORTHOCLONE OKT3	Monoclonal antibodies	THERAPEUTIC INJ	TRANSPLANT*
J7324	ORTHOVISC	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL)	THERAPEUTIC INJ	
C9399, J3490	OTREXUP	Methotrexate Injection	SELF-INJECTABLE	
J3490	OVIDREL	Chorionic gonadotropin 250 MCG/0.5ML INJ	SELF-INJECTABLE	INFERTILITY
J2700	OXACILLIN SODIUM	Oxacillin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0224	OXLUMO	Injection, lumasiran, 0.5 mg	THERAPEUTIC INJ	
J2590	OXYTOCIN	Oxytocin injection	THERAPEUTIC INJ	
C9399, J3490	OZEMPIC	SemaglutIde Soln, injection, for subcutaneous use	SELF-INJECTABLE	
J1096	OZURDEX	Dexamethasone intravitreal Implant	THERAPEUTIC INJ	
J9264	PACLITAXEL	Paclitaxel protein-bound particles, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9267	PACLitaxel	Paclitaxel, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9259	Paclitaxel	Injection, paclitaxel protein-bound particles (American Regent) not therapeutically equivalent to J9264, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9258	Paclitaxel protein-bound particles	Injection, paclitaxel protein-bound particles (Teva), not therapeutically equivalent to J9264, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9177	PADCEV®	Enfortumab vedotin-ejfv) for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590, C9399	PALYNZIQ	Pegvaliase-pqpz injection, for subcutaneous use	SELF-INJECTABLE	
J2430	PAMIDRONATE DISODIUM	Pamidronate disodium /30 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1566	PANGLOBULIN NF	Immune Globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1640	PANHEMATIN	Hemin, 1 mg	THERAPEUTIC INJ	
J1576	PANZYGA	Immune globulin intravenous, human - ifas 10% Liquid Preparation	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2440	PAPAVERINE HCL	Papaverine hcl injection	THERAPEUTIC INJ	
J9045	PARAPLATIN	Carboplatin injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0606	PARSABIV	Injection, etelcalcetide, 0.1 mg for intravenous use	THERAPEUTIC INJ	
90647	PEDVAX HIB	Hib vaccine, prp-omp, IM	THERAPEUTIC INJ	IMMUNIZATION
S0145	PEGASYS	Pegylated interferon alfa-2a, 180 mcg per mL	SELF-INJECTABLE	
J9314	PEMETREXED	Injection, pemetrexed (Teva) not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9294	Pemetrexed	Injection, pemetrexed (Hospira), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9296	Pemetrexed	Injection, pemetrexed (Accord), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9297	Pemetrexed	Injection, pemetrexed (Sandoz), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9304	PEMFEXY®	Pemetrexed IV soln 500 mg/20ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9324	PEMRYDI RTU®	Injection, pemetrexed, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90623	PENBRAYA™	Meningococcal ACYW (Tet Conj)-Mening B (Rcmb) Vacc For Inj	THERAPEUTIC INJ	IMMUNIZATION
J2540	PENICILLIN G POT IN DEXTROSE	Penicillin G potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2540	PENICILLIN G POTASSIUM	Penicillin G potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2510	PENICILLIN G PROCAINE	Penicillin g procaine injection	THERAPEUTIC INJ	
90698	PENTACEL	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
S0080	PENTAM 300 MG SOLUTION	Pentamidine isethionateper 300 mg	THERAPEUTIC INJ	
J2513	PENTASPAN 10%	Pentastarch 10% solution	THERAPEUTIC INJ	
S0028	PEPCID	Famotidine, 20 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9306	PERJETA	Pertuzumab Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J2798	PERSERIS	Risperidone for extended-release injectable suspension	THERAPEUTIC INJ	
J2540	PFIZERPEN-G	Penicillin g potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2550	PHENERGAN	Promethazine hcl injection	THERAPEUTIC INJ	
J2560	PHENOBARBITAL SODIUM	Phenobarbital sodium injection	THERAPEUTIC INJ	
J2760	PHENTOLAMINE MESYLATE	Phentolamine mesylate injection	THERAPEUTIC INJ	
J2372	Phenylephrine	Injection, phenylephrine HCl (Biorphen), 20 mcg	THERAPEUTIC INJ	
J2370	PHENYLEPHRINE HCL	Phenylephrine hcl injection	THERAPEUTIC INJ	
J1165	PHENYTOIN SODIUM	Phenytoin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399	PHESGO	Pertuzumab-trastuz-hyaluron-zzxf inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9600	PHOTOFRIN	Porfimer sodium, 75 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3430	PHYTONADIONE	Vitamin K phytonadione injection	THERAPEUTIC INJ	
S0081	PIPERACILLIN	Piperacillin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2590	PITOCIN	Oxytocin injection	THERAPEUTIC INJ	
90727	PLAGUE VACCINE	Plague Vaccine, IM	THERAPEUTIC INJ	IMMUNIZATION
J9060	PLATINOL AQ	Cisplatin 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9062	PLATINOL AQ	Cisplatin 50 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	PLEGRIDY	Peginterferon beta-1a soln pen-inj	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90732	PNEUMOVAX 23	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use (	THERAPEUTIC INJ	IMMUNIZATION
J3590,J9999	POLIVY	Polatuzumab vedotin-piiq for Intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0670	POLOCAINE	Mepivacaine HCL 10 ml	THERAPEUTIC INJ	
J0670	POLOCAINE-MPF	Mepivacaine HCL/10 ml	THERAPEUTIC INJ	
J1566	POLYGAM S/D	Immune Globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	POMBILITI™	Cipaglucosidase alfa-atga for IV solution	THERAPEUTIC INJ	
J9295	PORTRAZZA	Necitumumab	THERAPEUTIC INJ	CHEMOTHERAPY*
C9144	POSIMIR®	Bupivacaine infiltration soln 660 mg/5ml (132 mg/ml)	THERAPEUTIC INJ	
J3480	POTASSIUM CHLORIDE	Potassium chloride	THERAPEUTIC INJ	
S5012	POTASSIUM CHLORIDE in DEXTROSE SOLUTION	5% dextrose with potassium chloride, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9204	POTELIGEO	Mogamulizumab-kpkc injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	PRALUENT	Alirocumab Injection, for subcutaneous use	SELF-INJECTABLE	
C9399	PRAXBIND	Idarucizumab injection, for intravenous use	THERAPEUTIC INJ	
J3490	PRECEDEX	Dexmedetomidine hcl inj 200 mcg/2ml	THERAPEUTIC INJ	
J2650	PREDACORT 50	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2650	PRED-JECT-50	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2650	PREDNISOLONE ACETATE	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0725	PREGNYL	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J1410	PREMARIN	Estrogen conjugate 25 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
S0195	PREVNAR 16 MCG/0.5ML SUSP	Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years to nine years of age who have not previously received the vaccine	THERAPEUTIC INJ	IMMUNIZATION
90677	PREVNAR 20™	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3490	PREVYMIS	Letermovir injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2278	PRIALT	Ziconotide injection	THERAPEUTIC INJ	
J2260	PRIMACOR	Milrinone lactate / 5 MG	THERAPEUTIC INJ	
J2260	PRIMACOR IN DEXTROSE	Milrinone lactate / 5 MG	THERAPEUTIC INJ	
J0743	PRIMAXIN IV	Cilastatin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2670	PRISCOLINE	Totazoline hcl injection	THERAPEUTIC INJ	
J1459	PRIVIGEN	Immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg (Privigen)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0570	PROBUPHINE IMPLANT KIT	Buprenorphine hcl subdermal implant 74.2 mg	THERAPEUTIC INJ	
J2690	PROCAINAMIDE HCL	Procainamide hcl injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0780	PROCHLORPERAZINE EDISYLATE	Prochlorperazine, up to 10 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0885	PROCRIT	Epoetin alfa, (for non-ESRD use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
Q4081	PROCRIT	Epoetin Alfa, 100 Units (For ESRD On Dialysis) (For Renal Dialysis Facilities And Hospital Use)	SELF-INJECTABLE	
J0725	PROFASI	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J0725	PROFASI HP	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J7194	PROFILNINE SD	Factor IX, complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2675	PROGESTERONE	Progesterone per 50 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7525	PROGRAF	Tacrolimus injection	THERAPEUTIC INJ	TRANSPLANT*
J0256	PROLASTIN	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9015	PROLEUKIN	Aldesleukin, per single use vial	THERAPEUTIC INJ	CHEMOTHERAPY*
J0897	PROLIA	Denosumab 60MG/ML	THERAPEUTIC INJ	
J2950	PROMAZINE HCL	Promazine hcl injection	THERAPEUTIC INJ	
J2550	PROMETH-50	Promethazine hcl injection	THERAPEUTIC INJ	
J2550	PROMETHAZINE HCL	Promethazine hcl injection	THERAPEUTIC INJ	
J7401	PROPEL	Mometasone furoate sinus implant, 10 micrograms	THERAPEUTIC INJ	
J1800	PROPRANOLOL HCL	Propranolol injection	THERAPEUTIC INJ	
90710	PROQUAD	Measles, Mumps, Rubella and Varicella (Oka/Merck) Virus Vaccine Live	THERAPEUTIC INJ	IMMUNIZATION
J0270	PROSTIN VR 500 MCG	Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct physician supervision, not for use when drug is self-administered)	SELF-INJECTABLE	
J2720	PROTAMINE SULFATE	Protamine sulfate/10 MG	THERAPEUTIC INJ	
J3490	PROTONIX	Pantoprazole sodium, 40 mg	THERAPEUTIC INJ	
J2730	PROTOPAM CHLORIDE	Pralidoxime chloride injection	THERAPEUTIC INJ	
Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3415	PYRIDOXINE HCL	Pyridoxine hcl 100 mg	THERAPEUTIC INJ	
J1304	QALSODY	Tofersen Intrathecal Soln 100 MG/15ML (6.7 MG/ML)	THERAPEUTIC INJ	
90696	QUADRACEL	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)	THERAPEUTIC INJ	IMMUNIZATION
J0330	QUELICIN	Succinycholine chloride injection	THERAPEUTIC INJ	
J1201	QUZYTTIR	Cetirizine hydrochloride injection, for intravenous use	THERAPEUTIC INJ	
90675	RABAVERT	Rabies vaccine, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	IMMUNIZATION
J1301	RADICAVA	Edaravone injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q2026	RADIESSE	Calcium hydroxylapatite Implant	THERAPEUTIC INJ	
J2780	RANITIDINE	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2547	RAPIVAB	Peramivir Injection	THERAPEUTIC INJ	
C9399, J3490	RASUVO	Methotrexate Injection	SELF-INJECTABLE	
Q3028	REBIF	Interferon beta-1a injection	SELF-INJECTABLE	
J7203	REBINYN	Coagulation Factor IX (Recombinant), GlycoPEGylated lyophilized powder for solution for intravenous injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0896	REBLOZYL	Luspatercept-aamt for Subcutaneous inj	THERAPEUTIC INJ	
J0742	RECARBRIO	Imipenem, cilastatin, and relebactam for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3489	RECLAST	Zoledronic acid 1 mg Injection (Reclast)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7192	RECOMBINATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90743	RECOMBIVAX HB 10MCG/0.5ML	Hepatitis B vaccine, adolescent dosage (2-dose schedule), for intramuscular use (Price is per dose) (Recombivax HB 10mcg = one dose)	THERAPEUTIC INJ	IMMUNIZATION
90746	RECOMBIVAX HB 10MCG/ML	Hepatitis B vaccine, adult dosage, for intramuscular use 3 dose schedule	THERAPEUTIC INJ	IMMUNIZATION
90740	RECOMBIVAX HB 40MCG/ML	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90743	RECOMBIVAX HB 5MCG/0.5ML	Hepatitis B vaccine, adolescent dosage (2-dose schedule), for intramuscular use (Price is per dose) (Recombivax HB 10mcg = one dose)	THERAPEUTIC INJ	IMMUNIZATION
90746	RECOMBIVAX HB 5MCG/0.5ML	Hepatitis B vaccine, adult dosage, for intramuscular use 3 dose schedule	THERAPEUTIC INJ	IMMUNIZATION
~~J3490, C9399~~	~~REDITREX~~	~~Methotrexate injection, for subcutaneous use~~	~~SELF-INJECTABLE~~	
J7192	REFACTO	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1945	REFLUDAN	Lepirudin	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0243	REGEN-COV	Injection, casirivimab and imdevimab, 2400 mg	THERAPEUTIC INJ	
J2765	REGLAN	Metoclopramide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
Q5125	RELEUKO™	Filgrastim-ayow inj soln 300 mcg/ml	SELF-INJECTABLE	CHEMO ADJUNCT*
J2212	RELISTOR	Methylnaltrexone bromide injection	SELF-INJECTABLE	
J1745	REMICADE	Infliximab, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3285	REMODULIN	Treprostinil injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2004	RENACIDIN	Bladder calculi irrig sol	THERAPEUTIC INJ	
Q5104	RENFLEXIS	Infliximab-abda for Injection, for Intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0130	REOPRO	Abciximab injection	THERAPEUTIC INJ	
C9399, J3590	REPATHA	Evolocumab subcutaneous soln	SELF-INJECTABLE	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
S0122	REPRONEX	Menotropins 75 iu	SELF-INJECTABLE	INFERTILITY
Q5105	RETACRIT	Epoetin alfa-epbx, biosimilar, (retacrit) (for esrd on dialysis), 100 units	SELF-INJECTABLE	
Q5106	RETACRIT	Epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
J2993	RETAVASE	Injection, reteplase, 18.1 mg	THERAPEUTIC INJ	
J7311	RETISERT IMPLANT	Fluocinolone acetonide invitreal implant	THERAPEUTIC INJ	
J3485	RETROVIR	Zidovudine	THERAPEUTIC INJ	HIV/AIDS
J3490	REVATIO	Sildenafil Inj	THERAPEUTIC INJ	
C9399, J3590	REVCOVI	Elapegademase-lvlr injection, for intramuscular use	THERAPEUTIC INJ	
J3490	REZIPRES®	Ephedrine hydrochloride injection for intravenous use	THERAPEUTIC INJ	
J0349	REZZAYO™	Rezafungin for injection, for intravenous use	THERAPEUTIC INJ	
90386	RH Ig, IV	Rho(D) Immune Gobulin (RhIgIV), human, for intravenous use (Effective 3/30/06 Price is per 100 IU - previously Price was per 1500 IU) (see also J2790, Q4089	THERAPEUTIC INJ	
J7100	RHEOMACRODEX IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90384	RHO(D) Ig (RHIG)	Rho(D) Immune Globulin (RhIg), human, full dose, for intramuscular use	THERAPEUTIC INJ	
J2790	RHOGAM (HUMAN)	Injection, Rho d immune globulin, human, full dose, 300 mcg (see also Q4089, 90384, 90386)	THERAPEUTIC INJ	
J2791	RHOPHYLAC	Rho d immune globulin injection	THERAPEUTIC INJ	
Q5123	RIABNI™	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	THERAPEUTIC INJ	CHEMOTHERAPY*
J7178	RIASTAP	Injection, human fibrinogen concentrate, 1 mg	THERAPEUTIC INJ	
J1212	RIMSO-50	Dimethyl sulfoxide 50% 50 ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2794	RISPERDAL CONSTA	Risperidone 0.5 mg, Injection	THERAPEUTIC INJ	
J9312	RITUXAN	Rituximab,100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9311	RITUXAN HYCELA	Rituximab and hyaluronidase human injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	RIVFLOZA™	Nedosiran Sodium Subcutaneous Soln 80 MG/0.5ML	SELF-INJECTABLE	
J7200	RIXUBIS	Factor ix (antihemophilic factor, recombinant)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2800	ROBAXIN	Methocarbamol injection	THERAPEUTIC INJ	
J3490	ROBINUL	Glycopyrrolate 0.2MG/ML	THERAPEUTIC INJ	
J0696	ROCEPHIN	Ceftriaxone sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0696	ROCEPHIN IN DEXTROSE	Ceftriaxone sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1412	ROCKTAVIAN	Valoctocogene roxaparvovec-rvox	THERAPEUTIC INJ	
J1449	ROLVEDON	Eflapegrastim-xnst injection, for subcutaneous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3490	ROMAZICON	Flumazenil IV soln 0.5 mg/5ml	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9314	ROMIDEPSIN	Injection romidepsin non-lypohilized 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9318	ROMIDEPSIN	Romidepsin, non-lyophilized, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9319	ROMIDEPSIN	Romidepsin, lyophilized, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0596	RUCONEST	C1 esterase inhibitor (recombinant) for Intravenous Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5119	RUXIENCE	Rituximab-pvvr (Rituxan biosimilar)	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	RYANODEX	Dantrolene sodium for injectable suspension, for intravenous use	THERAPEUTIC INJ	
J9061	RYBREVANT	Amivantamab-vmjw	THERAPEUTIC INJ	CHEMOTHERAPY*
J2801	RYKINDO	Risperidone for extended-release injectable suspension, for intramuscular use	THERAPEUTIC INJ	
J9021	RYLAZE	Asparaginase erwinia chrysanthemi (recombinant)- rywn) injection, for intramuscular use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2998	RYPLAZIM	Plasminogen, human-tvmh)	THERAPEUTIC INJ	
J9333	RYSTIGGO	Rozanolixizumab-noli injection, for subcutaneous use	THERAPEUTIC INJ	
J2941	SAIZEN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J7131	SALINE BACTERIOSTATIC	Hypertonic Saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7130	SALINE FLUSH	Hypertonic Saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7516	SANDIMMUNE	Cyclosporine, parenteral, 250mg	THERAPEUTIC INJ	TRANSPLANT*
J2354	SANDOSTATIN	Octreotide injection, non-depot	SELF-INJECTABLE	CHEMO ADJUNCT*
J2353	SANDOSTATIN LAR DEPOT	Octreotide, depot form for intramuscular injection, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0491	SAPHNELO™	Anifrolumab-fnia) injection, for intravenous use	THERAPEUTIC INJ	
J9227	SARCLISA	Isatuximab-irfc iv soln 100 mg/5ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	SAXENDA	Liraglutide (weight management) soln pen-injector 6 mg/ml	SELF-INJECTABLE	
J3490	SCENESSE	Afamelanotide implant, 1 mg	THERAPEUTIC INJ	
Q2027	SCULPTRA	Poly-L-lactic acid Implant	THERAPEUTIC INJ	
J2850	SECRETIN SYNTHETIC HUMAN INJ	Secretin synthetic human	THERAPEUTIC INJ	
J2941	SEROSTIM	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J7189	SEVENFACT	Factor VIIa (antihemophilic factor, recombinant)-jncw, 1 mcg	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2561	SEZABY™	Phenobarbital injection, for intravenous use	THERAPEUTIC	
90750	SHINGRIX	Zoster Vaccine Recombinant Adjuvanted for IM Inj	THERAPEUTIC INJ	IMMUNIZATION
J3490/C9399	SIGNIFOR	Pasireotide injection, for subcutaneous use	SELF-INJECTABLE	
J2502	SIGNIFOR LAR	Pasireotide Injection	THERAPEUTIC INJ	
C9399, J3490	SILIQ	Brodalumab Injection	SELF-INJECTABLE	
C9399/J3590	SIMPONI	Golimumab 50 mg / 0.5ml Solution	SELF-INJECTABLE	
J1602	SIMPONI ARIA	Golimumab Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0480	SIMULECT	Basiliximab	THERAPEUTIC INJ	TRANSPLANT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2805	SINCALIDE	Sincalide injection	THERAPEUTIC INJ	
J7402	SINUVA	Mometasone furoate sinus implant, 10 micrograms	THERAPEUTIC INJ	
J3090	SIVEXTRO	Tedizolid phosphate Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	SKYRIZI®	Rosankizumab-rzaa injection, for subcutaneous use	SELF-INJECTABLE	
J2327	SKYRIZI®	Injection, risankizumab-rzaa, intravenous, 600 mg/10 mL (60 mg/mL) in each single-dose vial.. NDC 00074-5015-01	THERAPEUTIC INJ	
J3590	SKYSONA	Elivaldogene autotemcel IV suspension	THERAPEUTIC INJ	
J3590	SKYTROFA	lonapegsomatropin-tcgd) for injection, for subcutaneous use	SELF-INJECTABLE	GROWTH HORMONE
J7030	SODIUM CHLORIDE	Infusion, normal saline solution, 1000 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7040	SODIUM CHLORIDE	Infusion, normal saline solution, sterile (500ml = 1 unit	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7042	SODIUM CHLORIDE	5% dextrose/normal saline	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7050	SODIUM CHLORIDE	Normal saline solution infus	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7130	SODIUM CHLORIDE BACTERIOSTATIC	Hypertonic saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7331	SODIUM HYALURONATE 1%	Sodium Hyaluronate 1% for Intra-articular injection	THERAPEUTIC INJ	
J2590	SODIUM PHOSPHATE	Oxytocin injection	THERAPEUTIC INJ	
J3490	SOGROYA®	Somapacitan-beco injection, for subcutaneous use	SELF-INJECTABLE	GROWTH HORMONE
J3490	SOLESTA	Dextranomer-sodium hyaluronate injection	THERAPEUTIC INJ	
J2910	SOLGANAL	Aurothioglucose injeciton	THERAPEUTIC INJ	
C9399, J3490	SOLIQUA	Insulin Glargine-Lixisenatide Solution	SELF-INJECTABLE	
J1300	SOLIRIS	Eculizumab 10 mg/ml Soln	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1720	SOLU-CORTEF	Hydrocortisone sodium succinate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2920	SOLU-MEDROL	Methylprednisolone sodium succinate, up to 40 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	SOLU-MEDROL	Methlprednisolone sodium succinate, up to 125 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	SOLUREX LA	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1930	SOMATULINE DEPOT	Lanreotide acetate, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	SOMAVERT	Pegvisomant for injection	SELF-INJECTABLE	
J3490	Sotalol	Sotalol inj	THERAPEUTIC INJ	
J3490	SOTRADECOL	Sodium Tetradecyl Sulfate Injection	THERAPEUTIC INJ	
Q0247	SOTROVIMAB	Sotrovimab 500MG/8ML Solution	THERAPEUTIC INJ	
J1747	SPEVIGO®	Injection, spesolimab-sbzo, 1 mg , for intravenous use	THERAPEUTIC INJ	
J2326	SPINRAZA	Nusinersen injection, for intrathecal use -	THERAPEUTIC INJ	
J1835	SPORANOX	Itraconazole injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0595	STADOL NS	Butorphanol tartrate 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90717	STAMARIL	Yellow Fever Vaccine [Live])	THERAPEUTIC INJ	IMMUNIZATION
J3357	STELARA	Usetekinumab	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3358	STELARA IV	Ustekinumab, for intravenous injection, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9165	STILPHOSTROL	Diethylstilbestrol injection, 250 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5127	STIMUFEND®	Injection, pegfilgrastim-fpgk , biosimilar, 0.5 mg		
C9399, J3590	STRENSIQ	Asfotase alfa subcutaneous injection	SELF-INJECTABLE	
J2995	STREPTASE	Streptokinase /250000 IU	THERAPEUTIC INJ	
J3000	STREPTOMYCIN SULFATE	Streptomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3010	SUBLIMAZE	Fentanyl citrate injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q9991	SUBLOCADE	Buprenorphine extended-release less than or equal to 100	THERAPEUTIC INJ	
Q9992	SUBLOCADE	Buprenorphine extended-release over 100 mg	THERAPEUTIC INJ	
J0330	SUCCINYLCHOLINE CHLORIDE	Succinycholine chloride injection	THERAPEUTIC INJ	
S0039	SULFAMETHOXAZOLE	Sulfamethoxazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1961	SUNLENCA®	Lenacapavir injection, for subcutaneous use	THERAPEUTIC	HIV/AIDS
J7321	SUPARTZ	Sodium hyaluronate injection	THERAPEUTIC INJ	
J9226	SUPPRELIN LA, 50 MG	Histrelin implant	THERAPEUTIC INJ	
J1627	SUSTOL	Granisetron extended-release, 0.1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2779	SUSVIMO	Ranibizumab injection) for intravitreal use (Ocular Implant)	THERAPEUTIC INJ	
J2781	SYFOVRE™	Pegcetacoplan injection, for intravitreal use	THERAPEUTIC	
J2860	SYLVANT	Siltuximab for Intravenous infusion	THERAPEUTIC INJ	
J3490	SYMLIN	Pramlintide acetate Injection	SELF-INJECTABLE	
90378	SYNAGIS	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg	THERAPEUTIC INJ	
J2770	SYNERCID	Quinupristin/dalfopristin	THERAPEUTIC INJ	
J9262	SYNRIBO	Omacetaxine mepesuccinate for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7325	SYNVISC INJ	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
J7325	SYNVISC-ONE INJ	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
S0023	TAGAMET	Cimetidine hydroc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0593	TAKHZYRO	Landelumab-flyo	SELF-INJECTABLE	
C9399, J3590	TALTZ	Ixekizumab	SELF-INJECTABLE	
J3055	TALVEY	Talquetamab-tgvs injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3070	TALWIN	Pentazocine injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9265	TAXOL	Paclitaxel injection, 30 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9171	TAXOTERE	Docetaxel, 20 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0713	TAZICEF	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2053	TECARTUS	Brexucabtagene Autoleucel Suspension for IV Infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J9022	TECENTRIQ	Atezolizumab injection	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9380	TECVAYLI™	Teclistamab-cqyv injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0712	TEFLARO	Ceftaroline fosamil	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	TEGSEDI	Inotersen injection, for subcutaneous use	SELF-INJECTABLE	
J9328	TEMODAR 100 MG SOLR	Temozolomide, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90714	TENIVAC	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3241	TEPEZZA	Teprotumumab-trbw for IV Infusion	THERAPEUTIC INJ	
J1590	TEQUIN	Gatifloxacin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3105	TERBUTALINE SULFATE INJECTION USP	Terbutaline sulfate injection	THERAPEUTIC INJ	
J3490	TERLIVAZ	Terlipressin for injection, for intravenous use	THERAPEUTIC INJ	
J2460	TERRAMYCIN	Oxytetracycline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0189	TESTOPEL 75MG PELLET	Testosterone pellet, 75 mg	THERAPEUTIC INJ	
J1080	TESTOSTERONE CYPIONATE	Testosterone cypionate 200 MG	THERAPEUTIC INJ	TRANSGENDER HORMONES
J3121	TESTOSTERONE ENANTHATE	Testosterone enanthate injection, Up to 100mg	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
90389	Tetanus Immune Globulin (TIg), human, IM	Tetanus IG (Tig), human, IM	THERAPEUTIC INJ	
90703	TETANUS TOXOID	Tetanus Toxoid Adsorbed USP	THERAPEUTIC INJ	IMMUNIZATION
90718	TETANUS-DIPHTHERIA TOXOIDS TD	Tetanus and diphtheria toxoids (Td) adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J0120	TETRACYCLINE	Tetracycline	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2356	TEZSPIRE®	Tezepelumab-ekko injection, subcutaneous Solution **AUTO-INJECTOR** 210 MG/1.91ML 55513-0123-01	SELF-INJECTABLE	
J2356	TEZSPIRE™	Tezepelumab-ekko injection, for **SYRINGE** subcutaneous use 55513-0112-01- intended for administration by a healthcare provider.	THERAPEUTIC INJ	
J2810	THEOPHYLLINE IN D5W	Theophylline per 40 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90586	TheraCys 81 MG/VIAL SUSR	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3411	THIAMINE HCL	Thiamine hcl 100 mg	THERAPEUTIC INJ	
J9340	THIOTEPA	Thiotepa, 15 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3230	THORAZINE	Chlorpromazine hcl injection	THERAPEUTIC INJ	
J7197	THROMBATE III	Antithrombin III (human), per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7511	THYMOGLOBULIN	Antithymocyte globuln rabbit	THERAPEUTIC INJ	
J2725	THYREL TRH	Protirelin per 250 mcg	THERAPEUTIC INJ	
J3240	THYROGEN	Injection,thyrotropin alpha, 0.9 mg, provided in 1.1 mg	THERAPEUTIC INJ	
S0040	TICARCILLIN	Ticarcillin disod	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90585	Tice BCG 50 MG SUSR	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use (Price is per 50 mg)	THERAPEUTIC INJ	
90586	Tice BCG 50 MG SUSR	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9031	Tice BCG 50 MG SUSR	BCG (intravesical), per installation	THERAPEUTIC INJ	CHEMOTHERAPY*
J3250	TIGAN	Trimethobenzamide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3244	TIGCYCLINE	Injection, tigecycline (Accord) not therapeutically equivalent to J3243, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9273	TIVDAK®	Tisotumab vedotin-tftv for injection 40 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3101	TNKASE	Tenecteplase injection	THERAPEUTIC INJ	
J3260	TOBRAMYCIN SULFATE	Tobramycin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3260	TOBRAMYCIN SULFATE IN SALINE	Tobramycin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5133	TOFIDENCE™	Tocilizumab-bavi, biosimilar, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9181	TOPSAR	Etoposide 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1885	TORADOL IM	Ketorolac tromethamine injection	THERAPEUTIC INJ	
J3280	TORECAN	Thiethylperazine maleate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9330	TORISEL	Temsirolimus, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1190	TOTECT 500 MG SOLR	Dexrazoxane hydrochloride, per 250 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0365	TRASYLOL	Aprotonin, 10,000 kiu	THERAPEUTIC INJ	
Q5116	TRAZIMERA	Trastuzumab-qyyp,C1220 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9033	TREANDA 100 MG SOLR	Bendamustine HCl, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3315	TRELSTAR®	Triptorelin Pamoate For IM Susp 3.75mg, 11.25mg, 22.5mg	THERAPEUTIC INJ	
J1628	TREMFYA	Guselkumab injection, for subcutaneous use	SELF-INJECTABLE	
J7181	TRETTEN	Factor XIII (antihemophilic factor, recombinant)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3301	TRIAMCINOLONE ACETONIDE USP	Triamcinolone acetonide injection	THERAPEUTIC INJ	
J3300	TRIESENCE 40 MG/ML SUSP	Triamcinolone acetonide injectable suspension	THERAPEUTIC INJ	
J1443	TRIFERIC	Ferric pyrophosphate citrate solution, 0.1 mg of iron	THERAPEUTIC INJ	
J1444	TRIFERIC (For use in dialasate)	Ferric pyrophosphate citrate powder, 0.1 mg of iron	THERAPEUTIC INJ	
J1445	TRIFERIC® AVNU	Ferric pyrophosphate citrate solution 0.1 mg of iron	THERAPEUTIC INJ	
90721	TRIHIBIT PRESERVATIVE FREE	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3310	TRILAFON	Perphenazine injeciton	THERAPEUTIC INJ	
J3250	TRIMETHOBENZAMIDE HCL	Trimethobenzamide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3316	TRIPTODUR	Triptorelin pamoate for IM ER susp 22.5 mg	THERAPEUTIC INJ	
J9017	TRISENOX	Arsenic trioxide, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7329	TRIVISC	Sodium hyaluronate for intra-articular injection	THERAPEUTIC INJ	
J3320	TROBICIN	Spectinomycn di-hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9317	TRODELVY	Sacituzumab govitecan-hziy for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1746	TROGARZO	Ibalizumab-uiyk injection, for intravenous use	THERAPEUTIC INJ	
J0200	TROVAN	Alatrofloxacin mesylate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399, J3490	TRULICITY	Dulaglutide injection, for subcutaneous use	SELF-INJECTABLE	
90621	TRUMENBA	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5115	TRUXIMA	Rituximab-abbs	THERAPEUTIC INJ	CHEMOTHERAPY*
90636	TWINRIX	Hep a/hep b vacc, adult IM	THERAPEUTIC INJ	IMMUNIZATION
J3243	TYGACIL 50MG	Tigecycline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	TYMLOS	Abaloparatide injection, for subcutaneous use	SELF-INJECTABLE	
90691	TYPHIM VI	Typhoid Vi Polysaccharide Vaccine	THERAPEUTIC INJ	IMMUNIZATION
90692	TYPHOID VACCINE, H-P	Typhoid Vaccine, H-P, sc/id	THERAPEUTIC INJ	IMMUNIZATION
Q5134	TYRUKO®	Injection, natalizumab-sztn , biosimilar, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2323	TYSABRI	Natalizumab 1 mg injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9381	TZIELD™	Teplizumab-mzwv IV Soln 2 MG/2ML (1 MG/ML)	THERAPEUTIC INJ	
Q5111	UDENYCA	Pegfilgrastim-CBQV	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5111	UDENYCA	Pegfilgrastim-cbqv, biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5111	UDENYCA ONBODY™	Pegfilgrastim-cbqv On Body Injector	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1303	ULTOMIRIS	Ravulizumab-cwvz injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0295	UNASYN 1.5GM	Ampicillin sodium per 1.5 gm	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1246	UNITUXIN®	Injection, Dinutuximab, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1823	UPLIZNA	Inebilizumab-cdon injection, for intravenous use	THERAPEUTIC INJ	
J3350	UREAPHIL	Urea injection	THERAPEUTIC INJ	
J0520	URECHOLINE	Bethanechol chloride inject	THERAPEUTIC INJ	
J2679	UZEDY	Risperidone Subcutaneous ER Susp Prefilled Syr 200 MG/0.56ML	THERAPEUTIC INJ	
J2185	VABOMERE	Meropenem and vaborbactam for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2777	VABYSMO	Faricimab-svoa intravitreal inj 6 mg/0.05ml	THERAPEUTIC INJ	
90393	VACCINIA	Vaccinia IG, human, IM	THERAPEUTIC INJ	
J0900	VALERTEST #1	Testosterone enanthate and estradiol valerate	THERAPEUTIC INJ	CHEMOTHERAPY*
J3360	VALIUM	Diazepam, up to 5 mg	THERAPEUTIC INJ	
J9357	VALSTAR	Valrubicin, intravesical, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3370	VANCOCIN HCL	Vancomycin hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3371	VANCOMYCIN	Injection, vancomycin HCl (Mylan) not therapeutically equivalent to J3370, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3370	VANCOMYCIN HCL	Vancomycin hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9225	VANTAS IMPLANT	Histrelin implant	THERAPEUTIC INJ	CHEMOTHERAPY*
C9488	VAPRISOL	Conivaptan hydrochloride Injection	THERAPEUTIC INJ	
90632	VAQTA	Hepatitis A vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90633	VAQTA	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90396	VARICELLA-ZOSTER IMMUNE GLOB	Varicella-zoster IG, IM	THERAPEUTIC INJ	
C9399, J3490	VARITHENA	Polidocanol injectable foam	THERAPEUTIC INJ	
90716	VARIVAX	Chicken pox vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J3490 / 90396	VARIZIG	Varicella-zoster Immune Globulin (VZIG), human, for intramuscular use	THERAPEUTIC INJ	
J1642	VASCEZE	Heparin sodium injection per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2599	Vasopressin	Injection, vasopressin (American Regent) not therapeutically equivalent to J2598, 1 unit	THERAPEUTIC INJ	
J2598	Vasopressin	Injection, vasopressin, 1 unit	THERAPEUTIC INJ	
90697	VAXELIS™	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine,Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90671	VAXNEUVANCE™	Pneumococcal 15-valent Conjugate Vaccine) Suspension for Intramuscular Injection	THERAPEUTIC INJ	IMMUNIZATION
J2370	VAZCULEP	Phenylephrine hydrochloride Injection for intravenous use	THERAPEUTIC INJ	
J9303	VECTIBIX	Panitumumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5129	VEGZELMA®	Injection, bevacizumab-adcd biosimilar, 10 mg	THERAPEUTIC	CHEMOTHERAPY*
J0248	VEKLURY	Remdesivir, 1 mg	THERAPEUTIC INJ	
J9041	VELCADE	Bortezomib, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1756	VENOFER	Iron sucrose injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9376	VEOPOZ™	Pozelimab-bbfg inj soln	THERAPEUTIC INJ	
J2250	VERSED	Midazolam hydrochloride	THERAPEUTIC INJ	
J3400	VESPRIN	Triflupromazine hcl injection	THERAPEUTIC INJ	
J3465	VFEND IV	Voriconazole 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9219	VIADUR	Leuprolide acetate implant	THERAPEUTIC INJ	CHEMOTHERAPY*
J3095	VIBATIV	Telavancin injection	THERAPEUTIC INJ	
J3490/C9399	VICTOZA 18 MG/3ML SOLN	Liraglutide [rDNAorigin] Injection	SELF-INJECTABLE	
J9025	VIDAZA	Azacitidine injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1427	VILTEPSO	Viltolarsen	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1322	VIMIZIM	Elosulfase alfa	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9254	VIMPAT INJECTION	lacosamide, 1 mg	THERAPEUTIC INJ	
J9360	VINBLASTINE SULFATE	Vinblastine sulfate inj 1 mg/ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9370	VINCRISTINE SULFATE	Vincristine sulfate, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9390	VINORELBINE TARTRATE	Vinorelbine tartrate, per 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7333	VISCO-3	Hyaluronan or derivative for intra-articular injection, per dose	THERAPEUTIC INJ	
J3410	VISTARIL	Hydroxyzine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0740	VISTIDE	Cidofovir 375 mg injection	THERAPEUTIC INJ	HIV/AIDS
J3396	VISUDYNE	Verteporfin 0.1 mg injection	THERAPEUTIC INJ	
J3420	VITAMIN B-12	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3430	VITAMIN K	Vitamin K phytonadione injection	THERAPEUTIC INJ	
J3470	VITRASE 200 UNIT/ML SOLN	Hyaluronidase, up to 150 units	THERAPEUTIC INJ	
J3471	VITRASE 200 UNIT/ML SOLN	Hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)	THERAPEUTIC INJ	
J3472	VITRASE 6200 UNIT SOLR	Hyaluronidase, ovine, preservative free, per 1000 USP units	THERAPEUTIC INJ	
J9056	VIVIMUSTA™	Injection, bendamustine HCl , 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2315	VIVITROL	Naltrexone, Depot Form, 1 Mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7179	VONVENDI	Von Willebrand factor Recombinant	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
C9293	VORAXAZE	Glucarpidase Injection	THERAPEUTIC INJ	
J3490	VOXZOGO	Vosoritide for injection, for subcutaneous	SELF-INJECTABLE	
J3385	VPRIV	Velaglucerase alfa, 100 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3032	VYEPTI	Eptinezumab-jjmr	THERAPEUTIC INJ	
J3490	VYLEESI	Bremelanotide for subcutaneous use	SELF-INJECTABLE	
J1429	VYONDYS 53	Golodirsen IV Solution	THERAPEUTIC INJ	
J9332	VYVGART®	Efgartigimod alfa-fcab injection, for intravenous use	THERAPEUTIC INJ	
J9334	VYVGART® HYTRULO	Efgartigimod alfa and hyaluronidase-qvfc injection, for subcutaneous use	THERAPEUTIC INJ	
J9153	VYXEOS	Daunorubicin-cytarabine liposome for IV inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	WAINUA™	Eplontersen Sodium Subcutaneous Soln Auto-Inj 45 Mg/0.8ml	SELF-INJECTABLE	
J3490	WEGOVY®	Semaglutide (weight mngmt) solution	SELF-INJECTABLE	
J7183	WILATE SOLUTION	Injection, von Willebrand factor /Coagulation Factor VIII Complex, human	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2792	WINRHO	Injection, rho D immune globulin, intravenous, human, solvent detergent, 100 IU	THERAPEUTIC INJ	
J2510	WYCILLIN	Penicillin G procaine injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3490	XACDURO®	Sulbactam Sodium & Durlobactam Sodium co-packaged For IV Soln 1-1 GM	THERAPEUTIC INJ	
J3372	XELLIA	Injection, vancomycin HCl (Xellia) not therapeutically equivalent to J3370, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1558	XEMBIFY	Immune Globulin Subcutaneous, human-klhw 20%	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0691	XENLETA	Lefamulin injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0218	XENPOZYME™	Injection, olipudase alfa-rpcp, 1 mg	THERAPEUTIC INJ	
J0218	XENPOZYME™	Injection, olipudase alfa-rpcp, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0588	XEOMIN	IncobotulinumtoxinA	THERAPEUTIC INJ	
J0122	XERAVA	Eravacycline	THERAPEUTIC INJ	
J0897	XGEVA	Denosumab 120mg/ 1.7ml	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0775	XIAFLEX	Collagenase Clostridium Histolyticum Injection	THERAPEUTIC INJ	
J3299	XIPERE	triamcinolone acetonide injectable suspension), for suprachoroidal use	THERAPEUTIC INJ	
J2357	XOLAIR	Omalizumab, 5 mg	THERAPEUTIC INJ	DOFR Class change effective 2/14/08 as a result of FDA and Manufacturers recommendation due to black box warnings Re-reviwed Jan 11, 2022 no change
J3490	XULTOPHY	Insulin Degludec-Liraglutide Solution	SELF-INJECTABLE	
J2001	XYLOCAINE (CARDIAC)	Lidocaine injection	THERAPEUTIC INJ	
J7185	XYNTHA KIT	Factor VIII (antihemophilic Factor, recombinant), per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3490	XYOSTED	Testosterone enanthate solution auto-injector	SELF-INJECTABLE	
J9228	YERVOY	Ipilimumab Injection, for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
Q2041	YESCARTA	Axicabtagene ciloleucal, up to 200 Million autologous Anti-CD 19 Car T Cells, including leukapheresis and dose preparation	THERAPEUTIC INJ	CHEMOTHERAPY*
90717	YF-VAX	Yellow Fever vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9352	YONDELIS	Trabectedin for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J7314	YUTIQ	Fluocinolone acetonide, intravitreal implant, 0.01 mg	THERAPEUTIC INJ	
J9400	ZALTRAP	Ziv-aflibercept Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9320	ZANOSAR	Streptozocin injection, 1 gm	THERAPEUTIC INJ	CHEMOTHERAPY*
J2780	ZANTAC	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2780	ZANTAC IN NACL	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5101	ZARXIO	Filgrastim-sndz injection, biosimilar. 1 microgram	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5101	ZARXIO	Filgrastim-sndz injection, biosimilar. 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J0256	ZEMAIRA	Alpha 1-proteinase inhibitor, human, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3030	ZEMBRACE	Sumatriptan Succinate	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

INJECTABLE MEDICATION HCPCS / DOFR CROSSWALK

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0291	ZEMDRI	Plazomicin injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2501	ZEMPLAR	Paricalcitol 1 mcg	THERAPEUTIC INJ	
J7513	ZENAPAX	Daclizumab 25 mg, parenteral	THERAPEUTIC INJ	TRANSPLANT*
J3490	ZEPBOUND™	Tirzepatide (weight mngmt) solution	SELF-INJECTABLE	
J9223	ZEPZELCA	Lurbinectedin for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0695	ZERBAXA	Ceftolozane/tazobactam Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
A9543	ZEVALIN Y-90 3.2 MG/2ML KIT	Ibritumomab Tiuxetan	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5120	ZIEXTENZO	Pegfilgrastim-bmez injection, for Subcutaneous use	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5120	ZIEXTENZO	Pegfilgrastim-bmez injection, for Subcutaneous use	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J3490	ZILBRYSQ®	Zilucoplan Sodium Subcutaneous Soln Pref Syr 16.6 MG/0.416ML	SELF-INJECTABLE	
J3304	ZILRETTA	Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	THERAPEUTIC INJ	
J2310	ZIMHI™	Injection, naloxone HCl, 1 mg	SELF-INJECTABLE	
J0697	ZINACEF	Cefuroxime injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1190	ZINECARD	Dexrazoxane hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0565	ZINPLAVA	Bezlotoxumab injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5118	ZIRABEV	Bevacizumab-bvzr,10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0456	ZITHROMAX	Azithromycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2405	ZOFRAN	Ondansetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9202	ZOLADEX	Goserelin acetate implant	THERAPEUTIC INJ	CHEMOTHERAPY*
J3399	ZOLGENSMA	Onasemnogene abeparvovec-xioi	THERAPEUTIC INJ	
J3489	ZOMETA	Zoledronic acid 1 mg Injection (Zometa)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2941	ZORBTIVE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
90736	ZOSTAVAX	Zoster (shingles) vaccine, live, for subcutaneous injection	THERAPEUTIC INJ	IMMUNIZATION
J2543	ZOSYN	Piperacillin/tazobactam	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1632	ZULRESSO	Brexanolone injection, for intravenous use	THERAPEUTIC INJ	
J3590	ZYMFENTRA	Infliximab-dyyb injection, for subcutaneous use	SELF-INJECTABLE	
J9359	ZYNLONTA	Loncastuximab tesirine-lpyl) for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	ZYNTEGLO	Betibeglogene autotemcel	THERAPEUTIC INJ	
J9345	ZYNYZ™	Retifanlimab-dlwr IV Soln 500 MG/20ML (25 MG/ML)	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	ZYPREXA	Olanzapine, 2.5 mg	THERAPEUTIC INJ	
J2358	ZYPREXA RELPREV	Olanzapine Extended Release Injection	THERAPEUTIC INJ	
J2020	ZYVOX	Linezolid 200 mg injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

Rev. April 9, 2024

Effective October 7, 2024

MEDICARE INPATIENT AUTHORIZATION

CALIFORNIA HEALTHNET

Complete and Fax: 1-844-501-5713

For Standard (Elective Admission) requests, complete this form and Fax. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

X

EXPEDITED REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

***Indicates Required Field**

MEMBER INFORMATION

Last Name, First

Date of Birth *

(MMDDYYYY)

Member ID *

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

Requesting NPI *

Requesting TIN *

Phone

Requesting Provider Address

Fax *

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing Provider Contact Name

Servicing NPI *

Servicing TIN *

Phone

Servicing Provider/Facility Name Address

Fax

City, State, Zip

AUTHORIZATION REQUEST

Primary Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Start Date OR Admission Date *

(MMDDYYYY)

Diagnosis Code *

(ICD-10)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

(MMDDYYYY)

Additional Diagnosis Code

(ICD-10)

INPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes)

402 Skilled Nursing Facility	779 C-Section Delivery
492 Sub-Acute	970 Medical
411 Surgical	414 Premature/False Labor
992 Transplant	427 Rehab
720 Vaginal Delivery	121 Long Term Acute Care

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Rev. 10 05 2021

XE-PAF-1651

No-Cost Interpreter Services Available 24/7 for Your Patients

Your patients can access no-cost interpreter services.

Phone interpreters are available in over 150 languages for immediate needs.

Request in-person or video interpreters a minimum of five business days before the appointment during regular business hours. Allow 10 business days for in-person sign language interpreter requests.

When asking for an interpreter, tell us:

- The member's Health Net identification (ID) number
- The appointment date, time and place
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

Ask for no-cost interpreter services to help you effectively communicate with your patients.

Line of business	Phone number	Hours of availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	
Employer Group HMO, POS and PPO	800-641-7761	
After-hours language assistance line	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m., Pacific time; weekends and holidays
Medi-Cal	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m., Pacific time. For after hours select member option
Behavioral Health	800-647-7526	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)

For office use only. Do NOT post in a patient area.

Phone numbers listed here are for provider use only. Members may contact the number listed on the back of their ID card for member services.

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24-1158 (11/24)

Health Net Inc. a subsidiary of

CENTENE Corporation

SPECIAL NEEDS PLANS

MODEL OF CARE

Health Net of California H0562 Chronic Condition (C-SNP) 2019

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OVERVIEW

Health Net is an affiliate of Centene Corporation, a nationally recognized MCO offering Medicare, Medicaid, Commercial, Exchange, Medicare/Medicaid and US Department of Defense and Veterans affairs sponsored health insurance coverage for people of all ages and at all stages of life. In California, Health Net provides a coordinated C-SNP Model of Care for members with diabetes, congestive heart failure or cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorders). The Jade C-SNP is offered in Los Angeles, Kern, Orange and San Diego counties.

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION)

MOC 1.A DESCRIPTION OF OVERALL SNP POPULATION

MOC 1.A.1 Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.

Health Net(HN) follows the Centers for Medicare and Medicaid Services (CMS) requirements contained in Chapter 2 of the Medicare Managed Care Manual (MMCM) and in the applicable regulations in reviewing each enrollment election to ensure that the enrollee meets Special Needs Plans, (SNPs) eligibility requirements as applicable, prior to submitting the enrollment to CMS for approval. Upon receipt of the application, Health Net (HN) enrollment and eligibility specialists verify the enrollee's applicable chronic condition for the Jade SNP, based on the plan selected, through one of the following methods:

If the provider verification of condition is included with the application, HN will continue with the eligibility process outlined in "Processing the Enrollment Request", including sending the acknowledgement of enrollment notice:

- Once a day MP will receive a daily feed with all the previous day's enrollments in the Jade Plan. The member records are then assigned to each rep. based on effective date.

- The Attestation Unit (AU) must initiate the first attempt by phone call and/or by fax (if the Provider's office requests a fax be sent) of any newly enrolled C-SNP member within five (5) business days once the member is enrolled.

- The AU will continue the Provider outreach until either a verbal attestation or a signed Attestation Form is received. This process will continue until the last day of the members second month of enrollment to verify the member's qualifying chronic condition.

Documentation needed to proceed/make outreach to Provider

- Pre-Qualification Form and/or Attestation Form

- Look for the documentation in FileNet using both a HICN and/or searching by name.

- If BOTH the Pre-Qual and/or Attestations forms are NOT found, this must be brought to the attention of **Lead/Supervisor.**

- Member will need to be contacted to obtain a verbal pre-qualification over the phone.

- Once pre-qualification has been obtained, the form will be uploaded to FileNet.

- The AU will then begin the outreach to the Provider.

Steps taken after the 2nd month of enrollment

- On the 1st business day of the month the LEAD or LEAD designee will export a list of all active Jade members. The list of members exported will include those who were newly enrolled during the previous month however they were unable to be attested or do not qualify to remain enrolled in the Jade C-SNP plan.

    1) All Notices must be ordered by the 7th calendar day of the 2nd month of enrollment.
    2) In addition before ordering the notice for those who were unsuccessfully attested Membership will conduct a search in FileNet and OMNI by name and by HICN for any attestations or verbal attestations that may have been received.
    3) If by the end of the 2nd month of enrollment, there is no reply from the Physician or the Physician attests that the member does not qualify. The disenrollment transaction will be submitted

Additionally, HN will conduct follow up calls to the provider as needed to request verification of the qualifying condition. If confirmation is received either verbally or in writing, documentation is completed and updated to reflect this confirmation. HN will document in the appropriate system with all outreach attempts and outcomes and will retain a copy of any communication received in writing in the enrollee's file.

If by the end of the first month of enrollment, no confirmation has been received, HN will send the member a notice of his/her disenrollment for not having a qualifying condition. The disenrollment is effective at the end of the second month of enrollment, the disenrollment transaction is sent to CMS within 3 business days of the expiration of the deeming time frame; however, HN must retain the member if confirmation of the qualifying condition is obtained at any point during the second month of the enrollment.

If HN is unable to obtain provider verification of condition (and/or CMS approved prequalification assessment tool) HN will follow the pend process outlined in **"**Processing the Enrollment Request", including sending the enrollment pending notice to the enrollee.

Notice Requirements:

Request for Additional Information: To obtain information to complete the enrollment request, HN must contact the individual to request the information within **ten calendar days** of

receipt of the enrollment request. The request may be written or verbal but in either case the request must be made within ten calendar days.

Combination Acknowledgement and Confirmation Notice: A notice acknowledging and confirming an enrollee/member enrollment. This notice is sent within 7 calendar days of the availability of the Transaction Reply Report (TRR).

Provider Verification Form: A form to be completed by the provider to verify the enrollee's chronic condition.

CMS Approved Prequalification Assessment Tool: A notice that must be completed by the enrollee, which allows HN to contact the provider to verify the enrollee's chronic condition on a post-enrollment basis.

MOC 1.A.2 Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP Population.

Health Net's chronic disease Jade SNP for diabetes, chronic heart failure (CHF) and cardiovascular disorders provides healthcare services for residents of Kern, Los Angeles, Orange, and San Diego counties in the state of California. California is a large and populous state with several distinct geographic regions. The specific targeted areas include Kern County at the southern end of the Central Valley and three of Southern California's most populous counties encompassing the Los Angeles, Long Beach and San Diego metropolitan areas. San Diego County shares the Mexico border. Los Angeles, Orange, and San Diego are coastal, ethnically diverse regions with multiple large urban centers. According to the latest estimates of the U.S. Census Bureau, the populations of Los Angeles, Orange, and San Diego counties numbered over 10.1 million, 3.1 million, and 3.3 million people respectively as of July 1, 2016. Additionally, Los Angeles and Orange counties had higher proportions of foreign-born residents (34.7% and 30.5%, respectively) compared to California (27.0%) and the United States (13.2%); whereas San Diego County had a slightly lower proportion of foreign-born residents (23.5%) compared to California.[1,2,3] In contrast, Kern County is comprised of urban and rural areas in the Central Valley region that includes the large cities of Bakersfield and Delano. The county is widely known for its agricultural commodities and petroleum production. As of 2016, the population of Kern County reached 884,788 residents with nearly one in eleven persons (9.0%)

[1] United States Census Bureau. Quickfacts: Los Angeles County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[2] United States Census Bureau. Quickfacts: Orange County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[3] United States Census Bureau. Quickfacts: San Diego County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

being 65 years of age or older. More than half of Kern County residents are of Hispanic or Latino origin (52.8%) and less than one-fourth are foreign-born individuals (20.3%).[4]

The CA SNP includes members living in urban and rural areas of Kern, Los Angeles, Orange and San Diego counties still struggling with financial instability and poverty. The percentage of individuals living below the poverty level in Los Angeles County is 16.3%, more than the rate for both California and the nation (14.3% and 12.7%, respectively).[5] Particularly in Los Angeles, clusters of impoverished households are located in South Los Angeles and areas adjacent to the central downtown region. Many residents of these neighborhoods are Latino and foreign-born. As evidenced in the Orange County Community Indicator Report 2017, the cost of living in Orange County is almost double the U.S. average (87% higher) which could have a greater impact on older SNP members living on a fixed retirement income. Although less than Los Angeles County, families in one-third of Orange County neighborhoods face financial instability and 13% of residents live in poverty.[6] In comparison, the median household income of Kern County was $49,026 in 2015 and almost one-fifth (19.4%) of all families in Kern County had incomes below the poverty level. Poverty disproportionately affects Kern County residents and contributes to greater housing instability and food insecurity.[7] Furthermore, according to the American Community Survey, 14.5% of individuals in San Diego County, between 2009 and 2013, were living in households with income below 100% of the Federal Poverty Level (FPL). Also, a greater proportion of Latinos, African Americans, Native Americans, and individuals of some other race were in poverty compared to the overall San Diego population.[8]

Self-reported ethnicity information gathered from the 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[9] for HN California Medicare, inclusive of the SNP population, revealed that respondents were 82 percent White, 6 percent African American, and 16 percent Other. Of the aforementioned ethnicities, 31 percent of members designated themselves as Hispanic or Latino. About 45% reported a high school or less education and 55% had some college education or higher.

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[4] United States Census Bureau. Quickfacts: Kern County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[5] United States Census Bureau. Quickfacts: Los Angeles County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[6] Orange County Community Indicators Report. Retrieved December 6, 2017, from www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OC_Community_Indicators_2017.pdf

[7] Kern County Public Health Services Department. Community Health Assessment, 2015-2017. Retrieved December 6, 2017, from http://kernpublichealth.com/wp-content/uploads/2017/04/Community-Health-Assessment_04.18.17_1.pdf

[8] Penn TE, Delange N (2016). San Diego 2016 Community Health Needs Assessment. Retrieved December 26, 2017, from http://hasdic.org/2016-chna/

[9] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

An epidemiological and demographic analysis is conducted annually to assess the clinical needs of Health Net's SNP members (Jade, Amber I and Amber II). Demographic information from the most recent report identifies the average age of SNP members as of December 31, 2016 was 70.23, which was higher than the 2015 average age of 67.97 years. However, the SNP population continues to be younger than the non-SNP Medicare population by almost 3.3 years The Jade SNP population is comprised of 50 percent males and 50 percent females based on the latest HN HRA[10] data.

Social determinant data from the 2016 HN Health Risk Assessment (HRA) specific to the Jade SNP population identifies several deficits. About 45% of report they cannot shop for their own food and 48% report that they cannot cook their food. In addition, 24% of members depend on friends for transportation and 12.5% report trouble getting to doctor and dentist appointments. Barriers to accessing transportation are psychosocial factors that can contribute to missing doctor appointments, picking up prescriptions, and attending social events. A significant number (16%) also report that they do not have adequate social support. SNP members that cannot afford the essentials or perform tasks on their own, such as food shopping and cooking, buying clothes, dressing themselves and attending family events, experience a social deficit that can impact their physical and mental health.

Additional SNP Jade responses to the 2016 HN HRA revealed that English was the primary language for 63.4 percent, followed by Spanish (30.6%), Vietnamese (0.99%), Tagalog (0.93 %), Chinese (0.61%) and Korean (0.52%). Although 96% of these members reported they can read in their own language, health literacy may still be an issue. In order to address health literacy issues, Health Net provides culturally acceptable and readable materials for required threshold languages for vital documents. "Clear and Simple" guidelines at the eighth grade reading level are followed for additional materials. Health Net customer service representatives who speak Spanish or other languages are also available and required interpreter and language line services are provided. In 2016, Health Net received the Multicultural Health Care Distinction by the National Committee for Quality Assurance (NCQA) for the third time since 2012. Health Net has earned the two-year distinction for all three lines of business (Commercial, Medicaid and Medicare).

Please see MOC 1.A.3 for cognitive factors and co-morbidities of the Jade SNP population.

MOC 1.A.3 Identify and describe the medical and health conditions impacting SNP members

Cardiovascular Disease (CVD), which includes heart disease, heart failure, stroke and hypertension, accounts for one in three deaths in California, making it the leading cause of death in the state. The total number of deaths from CVD exceeds the combined number of deaths from diabetes, chronic liver disease/cirrhosis, accidents, Alzheimer's disease, influenza and pneumonia, and chronic lower respiratory diseases. Data collected on the presence of

[10] 2016HRAFrequinciesMY2016OverallSNPbyPBP

cardiovascular disease in California indicate that high blood pressure is present in one in four adults, high cholesterol is present in one in three adults, and nearly one in four adults is obese.[11] Diabetes is a major risk factor for cardiovascular disease. One in twelve adults (2.3 million) in California is diagnosed with diabetes. Diabetes is the seventh leading cause of death in California claiming nearly 8,000 lives annually.[12] People with diabetes ages 60 years old or older are 2-3 times more likely to report an inability to walk one-quarter of a mile, climb stairs, or do housework compared to people without diabetes in the same age group.[13]

Residents of Kern County experience a disproportionate burden of chronic disease compared to all other California counties. Chronic diseases/issues that were ranked highly include: obesity, high blood pressure, asthma, diabetes, cancer, heart disease and stroke. In fact, coronary heart disease (with 138.2 deaths/100,000 population) and cancer (with 156.1 deaths/100,000 population) account for more than one third of all deaths in Kern County. Additionally, diabetes is the sixth leading cause of death in Kern County (with 35.1 deaths/100,000 population); and Kern County is ranked worst in the state in terms of diabetes-related mortality. Furthermore, Kern County continues to have a higher proportion of obese adult residents (38.5%) compared to the rest of the state (28.0%). Being obese is clearly linked with an increased risk of serious health conditions such as diabetes, heart disease, stroke, and cancer.[14]

In comparison, the Jade SNP varies from the state population because members must have diabetes, CHF or cardiovascular disorders to enroll. Data from the 2016 HRA for Jade SNP members identifies the following incidence of medical, mental, cognitive and co-morbid conditions self-reported by members:

- 81% have diabetes
- 75% have hypertension
- 29% have impaired vision
- 28% have memory problems
- 20% have experienced a heart attack/have coronary artery disease
- 17% have asthma/chronic obstructive pulmonary disease (COPD)
- 12% have osteoporosis
- 10% have chronic kidney disease
- 9% have experienced heart failure

[11] Conroy SM, Darsie B, Ilango S, Bates JH (2016). Burden of Cardiovascular Disease in California. Sacramento, California: Chronic Disease Control Branch, California Department of Public Health.

[12] Conroy SM, Darsie B, Ilango S, Bates JH (2014). Burden of Diabetes in California. Sacramento, California: Chronic Disease Control Branch, California Department of Public Health.

[13] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[14] Kern County Public Health Services Department. Community Health Assessment, 2015-2017. Retrieved December 6, 2017, from http://kernpublichealth.com/wp-content/uploads/2017/04/Community-Health-Assessment_04.18.17_1.pdf

- 7% have mental health problems

Additional epidemiological and demographic analysis is conducted to assess the clinical needs of Health Net's Medicare SNP members (Jade, Amber I and Amber II). The SNP population is a subset of the Medicare population, and has an additional set of care requirements mandated by the Centers for Medicare and Medicaid (CMS). Another purpose of this activity is to identify trends in the SNP sub-categories and age groups. Top 10 diagnoses and Top 20 prescriptions in combination with member demographic information, are presented to assess the medical and behavioral health characteristics of this population.

In the Inpatient setting, Respiratory Failure, Septicemia, Other Nervous System Disorders and Acute and Unspecified Renal Failure were common to all age groups, both SNP and non-SNP. Other Connective Tissue Disease was in the Medicare non-SNP top 10 list, but not in the SNP top 10 list. Although Diabetes was common to all groups, SNP members tended to be hospitalized more than non-SNP members when Diabetes came with complications.

A member's age seemed to have a more direct bearing on the top 10 diagnoses list in the Inpatient setting than whether or not a member was SNP or non-SNP. Members 65 and above, SNP or otherwise, tended to be hospitalized for Acute Cerebrovascular Disease. Likewise SNP and non-SNP members 50 and above were more likely to be hospitalized for Congestive Heart Failure, Cardiac Dysrhythmias, Pneumonia and Coronary Atherosclerosis/Other Heart Disease. On the other hand, Mood Disorders, Schizophrenia and Epilepsy Convulsions were more pronounced in SNP members 49 and younger.

More commonality can be found in the Outpatient and Emergency settings. In the Outpatient setting, Diabetes Mellitus (both with and without complications), Essential Hypertension, Spondylosis, Other Connective Tissue Disease and Other Non-Traumatic Joint Disorders were common among all SNP and non-SNP age groups. Cataracts were more likely to be found in members 50 and older than in younger members, regardless of whether they were SNP members or not. In both SNP and non-SNP groups, Other Skin Disorders and Glaucoma were in the top 10 list of members 65 and older while members under 65 were more likely to have Other Nutritional Endocrine and Metabolic Disorders, and Other Upper Respiratory Infections. Epilepsy and Mood Disorders were more likely to be found in members younger than 50.

In the Emergency setting, six of the top 10 diagnoses were common to all age groups, both SNP and non-SNP: Diabetes with and without Complications, Spondylosis, Other Connective Tissue Disease, Other Skin Disorders and Disorders of Lipid Metabolism were common to all. Members 65 and older, regardless of whether they were SNP members or not, were more likely to seek treatment at Emergency rooms for Cataracts. Likewise, members 50 and older, both SNP and non-SNP, were commonly treated at Emergency rooms for Essential Hypertension.

Mycosis was more likely to occur in SNP, rather than in non-SNP, members 65 and over in an Emergency room setting. SNP members, younger than 65, were more likely to be treated at the Emergency room for Abdominal Pain and Other Non-traumatic Joint Disorders. Epilepsy and

Other Nervous System Disorders were more common causes of visits to the Emergency room for members 49 and under.

There was a greater correlation between the Non-SNP Medicare population and the 65-and-over SNP group than with the younger SNP age ranges in all settings.

There were very little differences in the top ten diagnoses among the Amber I, the Amber II and the Jade plans. If a diagnosis was in the top ten list of one but not another, it would be in the top 20 of the latter. With few exceptions, the top ten diagnoses in all settings in all plans were chronic conditions.

The Top 10 SNP inpatient and outpatient behavioral health diagnoses fell under the broad categories of Schizophrenia, Schizoaffective Disorders, Major Depressive Disorders and Bipolar Disorders. Health Net databases were also queried for behavioral health diagnoses, and the top 10 were obtained.

From January 1 through December 31, 2016, roughly 37.4% of the SNP population (8,297 out of 22,213) had a mental health diagnosis present in Health Net medical claims and encounters. Note that these were oftentimes not the primary diagnoses in the medical claims/encounter data.

Nineteen of the top 20 Enhanced Therapeutic Classification (ETC) drug categories in the SNP population as a whole are also in the top 20 drugs for the Non-SNP Medicare population. Medical Supplies, Musculoskeletal Therapy Agents and Antipsychotics are three medication categories that are in the SNP Top 20 list but not in the non-SNP Medicare list.

In review of the Average Days' Supply, Non-SNP Medicare members were more likely to have been on the indicated medication for a much longer time period than SNP members. However, SNP members without exception have much higher utilization rates than non-SNP Medicare members. Among the SNP population, medication duration was longest for Diabetic Therapy agents and shortest for Non-Narcotic Analgesics.

The utilization patterns of the SNP 65-and-over age group most closely resembles that of the Non-SNP Medicare population since 19 of the top 20 medications are in both lists. The patterns start to diverge in the 50-to-64 age range, but the most noticeable differences can be found in the under-50 age group.

Antipsychotics, one of the Top 20 most utilized drugs in the younger age groups, are not prominent in the Non-SNP Medicare population. Antipsychotic utilization is found mostly in the under-65 SNP age group and has a particularly high per capita utilization in the 49-and-under age range. It is ranked 17th in the 50-to-64 range but is 7th in the under-50 group.

Drugs with greater utilization for members aged 65 and over but whose utilization is not as pronounced in younger members are Anticoagulants, Calcium and Bone Metabolism Regulators

and Minerals/Electrolytes. The dose days per member tends to increase for these drugs as members get older. Members younger than 50 don't have the extent of prostatic problems as members 50 and older since members 50 and older have much greater utilization of Prostatic Hypertrophy Agents. Drugs with greater utilization for members aged 49 and under but have lower utilization in members older than 49 are Antipsychotics, Musculoskeletal Therapy Agents, Corticosteroids and Antiparkinson Therapy.

As for the similarities, the most utilized drug categories in all SNP and Non-SNP Medicare groups are those for Diabetic Therapy, Antihypertensive Therapy Agents, Antihyperlipidemics and Beta Adrenergic Blockers.

There is a strong association between the Top 10 medical diagnoses and the Top 20 prescriptions for the SNP population. SNP members tend to be hospitalized for Diabetes complications than non-SNP members. Analgesics and antidepressants continue to be in the Top 20 most prescribed drug categories, suggesting high occurrences of pain and depression.

However, there are marked differences between the SNP under-50 group and the older SNP population. SNP members under 50 years old tend to have a greater percentage of psychiatric disorders and antipsychotic medication than those older than 50. With regards to anticonvulsants, Dose Days per members tends to decrease with age.

Additionally, there is a greater correlation between the Non-SNP Medicare population and the 65-and-over SNP group than with the younger SNP age ranges in all settings as well as in drug utilization.

Diabetes, hypertension, hyperlipidemia/metabolic disorders and heart disease are prevalent not just in the SNP group but in the Medicare population as a whole, suggesting the need for more effective interventions to target chronic conditions.

Monitoring and surveillance of diagnoses and prescription lists are important in the development of programs and interventions to improve the quality of health care Health Net provides to all of its Medicare SNP members.

MOC 1.A.4 Define the unique characteristics of the SNP population served

The specific C-SNP type will be: Severe and Disabling Chronic Disease SNP for Diabetes, CHF, and Cardiovascular Disorders in Kern, Los Angeles, San Diego and Orange counties. Please see MOC 1.A.3 for disease incidence and prevalence including behavioral health disorders.

Unique characteristics of the Jade SNP population were identified through the 2016 HN HRA data. Overall, limitations and barriers reported suggest Jade SNP members are less mobile or independent with 32% having difficulty walking, 29% reporting weakness, 23% reporting shortness of breath and 22% with a fall in the past 12 months. About 15% experienced one or more hospital or nursing home admissions in the past 6 months and 26% required urgent or

emergency room care. The majority appear to have the resources they need to buy food, although 41% reporting difficulty affording food.

In addition, 39% of Jade SNP members reported that pain regularly interfered with performing daily activities with an average pain score rating of 6.7 out of 10. However, only about 31% of members reported effective pain control. Also, 27% of Jade SNP members indicated that they were bothered by emotional problems (such as feeling anxious, depressed, or irritable) in the past 6 months.

The purpose of targeting this population is to demonstrate that an improved Model of Care emphasizing case management and coordination of services can improve outcomes and balance utilization for members with diabetes, CHF, and/or cardiovascular disorders. SNP members with diabetes are at risk for complications such as cardiovascular disease, lower limb amputations, infections, kidney failure, non-healing wounds, hypertension, neuropathies and eyesight loss. SNP members with CHF are at risk for complications such as impaired kidney function, pulmonary congestion, weakness, arrhythmias, angina, pedal edema and heart attacks. SNP members with cardiovascular disorders such as cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorders are at risk for myocardial infarction, falls, stroke, pulmonary complications, circulatory impairment and leg wounds. In addition, members with one or more of these chronic conditions and accompanying side-effects may require complex medication regimens to treat symptoms and avoid complications.

The SNP population may also incur a loss of independence and cognitive decline especially when chronic disease such as diabetes, CHF and cardiovascular disease are not well-managed. Many have co-morbid conditions that further complicate the clinical course of their illness. They see multiple specialists and may have frequent emergency and inpatient stays which further contribute to coordination of care issues. Members identified at risk for chronic co-morbid diseases including coronary artery disease, heart failure, diabetes, asthma and COPD can be referred to a Disease Management program for additional support. Based on clinical trends, tailored quality improvement interventions and services are designed to address limitations and barriers and respond to the complex health care needs of these at-risk members.

1.B SUBPOPULATION-MOST VULNERABLE BENEFICIARIES

MOC 1.B.1 Define and identify the most vulnerable beneficiaries within the SNP population and provide a complete description of specially tailored services for such beneficiaries.

The most vulnerable populations will be identified in order to direct resources towards the members with the greatest need for case management services. Examples of vulnerable populations include but are not limited to:

- Frail – may include the super elderly (>85 years) and/or with diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty

- Disabled – members who are unable to perform key functional activities independently such as ambulation, eating or toileting, such as members who have suffered an amputation and blindness due to their diabetes or circulatory impairment.

- Dementia – members at risk due to moderate/severe memory loss or forgetfulness

- Mental Health conditions – members with behavioral health(BH) disorders may be at risk for additional complications due to their BH treatment and to barriers obtaining and coordinating their care

- ESRD post-enrollment – members with complex medical treatment plan for kidney failure

- End-of-Life – members with terminal diagnosis such as end-stage cancers, heart or lung disease

- Complex and multiple chronic conditions – members with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems

To identify the most vulnerable population within the SNP, the member's stratification is determined when the clinical assessment is conducted by Case Managers. Upon member status changes such as complications or inpatient admissions and at least annually, stratification could be revised based on the determination of the Case Manager. The stratification is determined across three dimensions: medical, psychosocial, and cognitive/functional. The case manager reviews pertinent available data during assessments/reassessments which include utilization and predictive model results. If stratification levels are revised based on reassessment, it is documented in the medical management system.

Specialty Services and Benefits

In addition to a coordinated care model, Health Net offers SNP members a number of specialty services and benefits designed to meet their additional and unique healthcare needs. These benefits vary by region and SNP plan and the specific Explanation of Coverage should be referenced each year for exact details.

- **Transportation Services:** Health Net provides transportation services to Jade SNP members as part of their core supplemental benefits; this includes a variable number of medically related trips annually according to the individual SNP plan. Members are provided with the benefit and contact information for transportation services upon enrollment so they can access services directly. The member can bring a caretaker or family member for no charge.

Members may ask the driver to stop at a pharmacy for prescription pick-up after a physician visit, and the stop will not count as an additional trip. Moreover, convenient curb-to-curb or door-to-door assistance is offered depending upon the member's need. The expected outcome is that provision of transportation services will promote member access to medical services and compliance with the medical goals of the Care Plan.

- **Dental/Vision Benefit:** Members are provided with vision and dental benefits, provider directories and contact information for dental and vision services upon enrollment so they can access these services directly. The member's Case Manager will also educate members about these benefits and encourage them to obtain regular dental and vision care. The expected outcome is that members will have improved oral health, prevention or early detection of dental and visual complications and access to eyewear as needed.

    - **Vision Benefit:** Jade members have core supplemental vision benefits. The vision benefit includes an annual routine eye exam and eyewear allowance for frames and lenses or contact lenses every two years. This is especially important for diabetics, elderly and those with hypertension who are at greater risk of vision loss and complications.

    - **Dental Benefit:** Depending on the individual plan, Jade members have core supplemental dental benefits or can purchase these benefits as an optional supplemental package. Dental benefits can range from diagnostic x-rays, preventive cleaning and services, restorative amalgam dental treatments and discounts for other services to a comprehensive dental benefit. Good oral care has been linked to general medical health.

- **Hearing Services:** Jade members have core supplemental hearing aid benefits. Hearing aid coverage includes an annual hearing exam and hearing aids and fitting every three years. The hearing aid provider sends a patient guide with detailed information on hearing loss, hearing aids and what to expect during first appointment. The expected outcome of this benefit is improved communication and comprehension for members along with the accompanying social and medical benefits.

- **myStrength:** myStrength is a web-based and mobile-app tool available to all Health Net members to address depression, anxiety, substance use, pain management and insomnia. myStrength can also be used by providers to support their patients in managing their behavioral health conditions. The expected outcome is that SNP members with behavioral health conditions will have an additional option and support tool to self-manage and meet their behavioral health needs.

- **Fitness:** Jade members are offered a Fitness Program at no additional cost. The fitness benefits include a membership at a participating fitness facility and access to exercise classes (available at some facilities). It also includes online educational materials and exercise programs for members who do not utilize the gym.

- **Medication Therapy Management (MTM):** All SNP members are enrolled in the MTM program with quarterly medication reviews by a pharmacist. The review looks for evidence of noncompliance, gaps in care, duplication or potential for adverse reactions and the member, physician and HN Case Manager receive the results of the review when problems are identified, in addition to information on how to speak with a pharmacist directly. This communication among the team members facilitates follow-up with the member regarding medication issues. The pharmacy reviews will be provided automatically and the member is provided with the contact information for the pharmacist to access additional medication information, if desired. The expected outcome is increased knowledge of their medication profile, improved compliance, and decreases in gaps in care, duplication of medications and adverse reactions.

- **Disease Management:** SNP members have access to a health care professional for education and counseling regarding health concerns and biometric monitoring when indicated. The focus is on members with chronic disease such as diabetes, chronic heart failure, COPD and asthma to improve disease management and decrease unplanned admissions. In addition to providing educational materials and educating the member how to manage their disease process, there is access to interactive programs on the member portal regarding smoking cessation, increasing physical activity and weight management and a comprehensive library of health information. Care gap reminders are also sent for gaps in care such as preventive screening and medication adherence. Members are provided with education and contact information about how to access disease management services upon enrollment. The member's Case Manager and providers can also refer members to disease management as indicated. The expected outcome is for members to have improved knowledge and management of their disease process resulting in a decrease in unnecessary utilization and improved quality of life.

- **Chronic Disease specific:** Depending on the region and specific SNP plan, members in Chronic Disease SNPs may have access to such benefits as zero or lower costs for diabetic monitoring supplies, diabetes self-management training, Medicare covered routine or intensive cardiac rehab, supplemental podiatry visits, oxygen or covered pulmonary rehab services. Additionally, select cardiovascular and diabetic drugs are made available to SNP members for zero dollars out-of-pocket. Add-on benefits are re-evaluated annually to meet member needs.

- **Case Management for Special Needs:** All SNP members are enrolled in case management. In addition, for a small subset of members with conditions such as ESRD, catastrophic or end-of-life situations, members may be enrolled in more specialized case management programs which include home visits. The member's Case Manager or provider will refer the member for the services.

- **Social Workers and/or Case Managers:** County–specific research is conducted to identify and connect members with additional resources in their community to meet their individual needs. These can range from assistance for home modifications such as ramps, financial

assistance, support groups, home delivered groceries and meals, in-home supportive services, transportation, etc.

- In addition, SNP members may receive the following interventions as indicated by their individualized Care Plan:

  - HRA and initial assessment done at least annually
  - Condition specific assessment and condition detail may be performed at least quarterly for members with any applicable HCC condition (all conditions assessed) depending on member's acuity.
  - Chronic care guidelines utilized for condition specific care plan and interventions, as appropriate
  - If available, utilize internally developed evidence based conditions specific to case management process guidelines, such as Diabetes, COPD, CHF, and CAD
  - Coordination of multiple services, such as home health, PT, OT, wound care, DME, specialty visits, etc. (5+)
  - Coordination of care with multiple external entities (i.e. Department of Social Services, Medicaid, etc.)
  - Referral for disease management
  - Surveillance for potential status changes such as ER visits, hospitalizations, claim data

MOC 1.B.2 Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries.

Age – As of December 31, 2016, the HNCA SNP average was 70 years. The older a member is, the more likely they are to have degenerative diseases such as failing vision, hearing, impaired cognition, changes in kidney and liver function and loss of mobility. All of these can impact their ability to understand and manage their disease process, follow a healthy exercise routine and metabolize medications and puts them at greater risk of adverse drug reactions and falls and injuries.

Gender – The Jade SNP population is comprised of 50% males and 50% females. It is important to women's health that they receive regular screening for breast and cervical cancer and osteoporosis in particular. Research has also identified that women are less likely to obtain the necessary screening for cardiovascular disease than men. In addition to routine screening for chronic diseases such as hypertension, coronary artery disease and diabetes, men require regular screening for disorders of the prostate.

Ethnicity – Self-reported ethnicity information gathered from the 2017 CAHPS® for HNCA Medicare, inclusive of the SNP population, revealed that respondents were 82% White, 6% African American, 16% Other. Of the aforementioned ethnicities, 31% of members designated

themselves as Hispanic or Latino. California has a large immigrant population. From the "Racial and Ethnic Disparities in Health Care in Medicare Advantage" report released in 2016 by the CMS Office of Minority Health, health disparities exist for Black and Hispanic populations. Utilizing CAHPS/HEDIS data collected in 2014, the Office identified that Black and Hispanic populations had significantly lower results compared to Whites for some access, preventive care and health outcomes. For access to care, these included getting needed and specialist care, getting appointments and care quickly and getting prescription drugs. Significantly lower rates for preventive care were observed for annual flu vaccine and colorectal cancer screening. Important health outcome rates such as control of blood sugar and blood pressure were also lower, especially for the Black population.

Language barriers – For non-English speakers, language can be a communication road block and have a negative impact on quality care and health outcomes. English was the primary language reported for 63.4% of Jade SNP members, followed by Spanish (30.6%), Vietnamese (0.99%), Tagalog (0.93 %), Chinese (0.61%) and Korean (0.52%). Language barriers are addressed with ongoing action plans that include distribution and utilization of a cultural and linguistic provider toolkit and continued provision of a comprehensive Language Assistance Program. Health Net provides required language and interpreter services to meet member needs.

Health Literacy - Self-reported member information gathered from the 2017 HNCA CAHPS®, inclusive of the SNP population, revealed that 45% reported a high school education or less and 55% have had some college education or higher. The 2016 HN Jade SNP HRA data indicated that 96% of members can read in their own language. However, research has shown that even college educated persons can have very low health literacy. Low health literacy can impact the ability of members to understand and follow the instructions provided to manage their conditions. Easy to understand language and communication is promoted in Health Net member materials.

Socioeconomic status – About 41% of Jade SNP members report having trouble affording to buy food. Not being able to afford the essentials, such as food, clothing, transportation, and housing creates a social deficit and can lead to behavioral health problems such as depression. Not being able to purchase fresh fruits and vegetables due to price or mobility issues and buying high caloric and high sodium processed foods instead can result in poor control of chronic diseases such as diabetes, CHF and cardiovascular disorders. Low income members with concerns about additional costs for healthcare visits, medications or testing supplies may avoid medical appointments or preventive care.

Other – The 2016 HN HRA data indicated that 45% of Jade SNP members report that they cannot shop for their own food and 48% reported that they cannot cook their food. About 24% relied on friends as the main mode of transportation; 4% use the services of a medical specialty van, and 4% use public transportation. In addition, 16% report that they do not receive adequate social support. These factors can have an impact on member's physical and emotional health and ability to follow their doctor's treatment plan. Members who live alone may require

assistance with additional long-term care supports and services such as delivered meals, help with household chores and identification of social supports in the community. Members without transportation may have difficulty making doctor's appointments for preventive and routine care.

MOC 1.B.3 Illustrate a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.

The focus of Health Net's California Jade SNP for Diabetes, CHF and Cardiovascular Disorders will be on coordinated care, transitions of care, treatment and condition-specific education to improve disease management and prevent unnecessary admissions. The fundamental structure of the SNP Model of Care such as Case Management for all members (especially the most vulnerable SNP population), Health Risk Assessments, Individualized Care Plans, management of Transitions of Care, Interdisciplinary Care Teams and add-on benefits like Disease Management and Medication Therapy Management will assist high risk members with Diabetes, CHF and Cardiovascular Disorders to navigate complex healthcare systems and promote improved self-management of their chronic conditions.

The special services and supports provided to address the demographic characteristics described in MOC 1.B.2 will include:

Age – Case Managers are provided with additional training and regular inservices to improve their skills at working with the elderly, disabled and chronic diseases of the elderly including those with sensory and cognitive impairment such as dementia, diabetes, heart disease and bariatric surgery. They also assess members for safety issues such as fall risk, medication safety risk and ability to manage their care needs. Specialized services for older and disabled members include making core documents and other materials available in alternative formats to meet the needs of members with visual impairment. A 711 relay number, office interpretation services, and Speech-to-Text interpreting meet the needs of members with hearing impairment. The Fitness Program includes fall prevention, home exercise kits and other healthy exercise programs designed for older adults.

Gender – Case Managers promote preventive screening for male and female members. There are also quality improvement programs to identify elderly women with fractures so appropriate treatment for osteoporosis can be provided if indicated. HN also monitors if members have obtained preventive care or screenings for breast, colorectal and flu vaccine and provides reminders when care gaps are identified.

Ethnicity – To address health disparities for some populations, the Disease Management and Health Education programs develop educational material and interactive programs available in English and Spanish on chronic diseases and conditions such as fall prevention, osteoporosis, diabetes, depression, high blood pressure, weight management, preventive screening and smoking cessation. Case Managers, and if indicated Disease Managers reach out to members, including Hispanics and African Americans identified with care gaps to encourage regular follow-up care with their doctors. Bi-lingual Case Managers and educational materials in English

and Spanish are made available as much as possible. The member portal also has educational material on chronic disease and online interactive programs promoting exercise and to help members attain their ideal weight.

Language barriers – Health Net has an active language line program that is available to members and/or caregivers and Health Net associates and contracted providers when the member needs assistance. Core documents and other materials are available in English and Spanish and can be translated upon request. Core materials are also available in alternative formats. Interpreter services and oral translation services to communicate with the plan are offered to all limited English proficient (LEP) members. Interpreter services including sign language services will be available at all medical points of contact at no cost to the provider for all Health Net LEP members. In addition, population assessments are conducted to monitor language needs, quality standards for timely delivery, and quality of services and oversight to ensure effective service.

Health Literacy – Although the majority of HN Jade members report they can read in their own language, they may have health literacy issues. They may not have the skills to correctly follow directions on prescription bottles, understand medication and disease literature or read other health materials that may be at a high grade level. Health Net launched the Clear and Simple initiative in 2010 in an effort to address health literacy issues by promoting the use of plain language. At its most basic, *health literacy* is our ability to gather, process and understand health information in order to make sound health care decisions. Using plain language in communication with members improves health literacy and readability tools are utilized to attain the ideal grade level.

Socioeconomic status – HN has designed special benefits for the SNP Jade plan to meet the needs of older adults who are on a fixed income. Due to the high prevalence of chronic conditions such as hypertension and diabetes, a pharmacy benefit covers much of the cost for regular prescription drugs to manage chronic diseases. This can include zero or lower costs for select cardiovascular and diabetic drugs, and diabetic testing supplies. With respect to other challenges, Health Net provides medically related transportation services and hearing aid coverage for Jade SNP members.

Other – In addition to a comprehensive network of behavioral health providers for members with behavioral health needs, Health Net provides *mystrength*, an online tool for members described in MOC1.B.1. To meet the needs of members with diabetes, CHF and cardiovascular disease, Health Net has additional disease management services as described in SNP MOC 1.B.1 under specialty services.

MOC 1.B.4 Identify and Describe Established Relationships with Partners in the Community to Provide Needed Resources

HN Case Managers and Social Worker's maintain a good working knowledge of community resources in the member's geographic location and provide the member with coordination of

services to assist them to meet their needs. This includes establishing relationships with the providers of services. Social Workers and/or Case Managers conduct county–specific research to identify and connect members with the resources in their community to meet their individual needs. These can range from assistance for home modifications such as ramps to financial assistance, support groups and in-home supportive services.

Health Net collaborates with its participating provider groups in order to enhance member care. Actionable data is shared on a regular basis with providers on care gaps, member pharmacy issues, results of member surveys and other data for providers to follow-up and perform outreach with members. Health Net also provides access to online clinical practice guidelines and member educational tools around chronic heart failure and diabetes to provider partners for optimum disease management. The online provider portal provides access to member level data on the HRA, authorizations, claims and other information.

Health Net partnered with the Alzheimer's Association in 2014 to provide training for Case Managers working with members diagnosed with dementia and other related disorders. A case consultant is available to care managers for up to 6 months after training has been completed to provide consultation and to participate in care conferences. The first year of the training is a pilot with modifications occurring in the 2nd and 3rd years. There is also a Caregiver Education component for families caring for relatives with dementia. In September 2016, the Alzheimer's Association collaborated with Health Net and its delegate case managers to implement the Dementia Specialist Program.

Health Net's partnership with the American Cancer Society (ACS) is aimed at improving the health of our members and activating our communities to join the fight against cancer. Health Net leverages ACS education materials, branding, and best practices for member outreach to increase preventive care including breast cancer and colon cancer screenings. In addition, Health Net has joined an initiative sponsored by the National Colorectal Cancer Round Table and American Cancer Society to improve colorectal cancer screening rates to 80% by 2018. With over 400 collaborating organizations, the initiative builds momentum and awareness in the healthcare community to implement programs that allow for easier screening.

Health Net partners and collaborates with California Quality Collaborative (CQC) to provide training and share best practices, successes and challenges in patient care and clinical operations to medical groups, Independent Practice Associations (IPAs) and PPGs. Topics, webinars and symposiums vary annually but include Practice Facilitation Initiatives, Opioid Safety and Avoiding Readmissions to improve outcomes and patient experience.

Representatives from Health Net's clinical services attend the Right Care Initiative –a collaborative to improve critical prevention metrics for heart attack, stroke and diabetes complications through patient-centered, evidence-based medicine. Monthly meetings in southern and northern California locations provide an interactive educational platform for local health care leaders and other stakeholders to exchange proven clinical strategies used to achieve benchmark outcomes and discuss ways to apply evidence-based practices in local

settings. Topics in 2017 included: “Achieving Change at Large Scale, Lessons for Improving Patient Outcomes From Around The World”, “Prevention of Cardiovascular Disease: What’s New in Hypertension and Dyslipidemia”, “Clinical Strategies for Multi-Cultural Patients” , “LA Firefighters 10 year CVD Reduction Success Story “,No More Broken Hearts Foundation “, “Kaiser Permanente Systemic Lipid Treatment and Risk Reduction “, “Diabetes Management Strategies Effectively Deployed within One National Top Performer “,Heart Failure and Other Patients on High-Risk Medications: Reducing Readmissions and Preventing ADEs”.

Health Net supports the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients’ efforts to improve quality, safety and affordability of health care. The Partnership for Patients focuses on making hospital care safer, more reliable and less costly through the achievement of (1) reducing hospital-acquired conditions (HACs) by 20% and (2) reducing 30-day hospital readmissions by 12%. In order to achieve these goals, the Partnership for Patients has replaced and expanded the Hospital Engagement Networks (HENs) with a new similar initiative called Hospital Improvement and Innovation Networks (HIINs), which includes hospital associations and health systems. Health Net has pledged to work towards attaining the goals of this initiative and most Health Net contracting hospitals and respective providers are already collaborating with HENs to share best practices, report and share quality data, and identify effective strategies to reduce HACs and readmissions.

MOC 2: CARE COORDINATION

MOC 2.A SNP STAFF STRUCTURE

MOC 2.A.1 Describe the administrative staff’s roles and responsibilities, including oversight functions.

Centene Corporation is the parent company of Health Net; within the corporate structure, the Corporate Executive Vice President oversees the Corporate Medicare CEO. The Medicare CEO oversees the Corporate Director of Compliance and Regulatory Affairs and at the Plan level, the Health Net structure includes the Senior Vice President of Government Relations and Compliance. Health Net has a dedicated Medicare Sales Team, as well as dedicated Enrollment and Marketing staff. The Medicare Medical Management staff is a separate multidisciplinary team receiving support from other plan departments such as Quality Improvement/Management, Pharmacy, Member Services, Provider Services and Claims.

Centene Corporation provides executive and operational support to Health Net and offers specialty affiliates and contracted vendors that serve Health Net. These include affiliates who may participate in the care of Medicare members such as: *Envolve* Pharmacy Solutions for Pharmacy Benefit Management (PBM); *Envolve People Care – MHN* Behavioral Health Management, and *US Medical Management* for in home physician services.

To ensure a seamless operational integration of services, Health Net utilizes existing employed and contracted staff to manage the administrative services noted throughout the Model of Care, in addition to hiring staff as needed to supplement any additional functions.

Currently, the Health Net Quality Improvement Committee (HNQIC) has oversight of the QI Program including SNP and has delegated authority from the Health Net Boards of Directors. Please see complete information in SNP MOC 4.A.3. In addition, the administrative functions and the corresponding staff structure to implement the SNP program is summarized in Tables 2.1. See the job description summaries in MOC 2.A.3 and organizational charts at end of this document for more details.

Administrative Functions

The following describes the specific employed or contracted staff that performs administrative functions for the C-SNP program, by functional area. Each department has a VP/Director/Manager responsible for oversight of activities pertinent to their specialty area.

Enrollment and Eligibility Verification

Enrollment Specialist and Enrollment Supervisor are responsible for the following:

- Verify Medicare and Medicaid eligibility
- Process enrollments and voluntary and involuntary disenrollment according to CMS guidelines and within CMS required timeframes
- Maintain an internal member database and ensure data accuracy by conducting reconciliation with CMS (TRR- Transaction Replay Report) and State Medicaid files

Member Service

Member Service Representative and Member Services Supervisor are responsible for the following:

- Handle inbound/outbound call center activities
- Conduct new member welcome call to introduce the member to the Member Service unit, explains benefits, answers questions, assist with PCP selection
- Verify Eligibility
- Answer member inquiries

Claims

Claims Specialist are responsible for the following:

- Process claims for contracted and non-contracted providers
- Assess payment accuracy and conducts recoveries of overpayment

Appeals and Grievances (A&G)

A&G Coordinators are responsible for the following:

- Intake and resolution of member grievances according to CMS timelines

- Coordinates with the Quality Management department in the resolution of member quality of care complaints
- Intake of reconsiderations and coordination with the Medical Management department for resolution
- Intake for appeals processing

Provider Services

Provider Services Representative, Credentialing Specialist and Director of Network Management are responsible for the following:

- Receive and resolve provider inquiries
- Manage Health Net website provider directory
- Setup & Contracting for Providers
    - Primary resource between providers and plan
    - Investigate and communicate resolutions to provider issues
    - Recruit new providers
    - Credential and re-credential providers
    - Manage providers' education
    - Ensure access and availability to providers to meet members' needs.

Marketing/Communications

Marketing Manager and Marketing Team are responsible for the following:

- Develop communication articles and materials for distribution to stakeholders
- Develop and distribute member & provider educational materials
- Develop marketing materials

Finance

Chief Financial Officer is responsible for the following:

- Collect and analyze financial data to support operations
- Develop and manage the financial budget and conduct appropriate planning including actuarial projections
- Manage risk management program
- Monitor HCC risk adjustment

Training

Compliance Director, Director Medical Management, Director Network Management and Director Service Coordination are responsible for the following:

- Assess and identify individual and group training needs through key business indicators and develop various training curricula, materials and aids
- Coordinate training efforts to meet training demands through peer shadowing, classroom classes and online presence

- Oversee the auditing of team results and identify gaps in training and implement improvements in training programs

Regulatory & Compliance
Compliance Director is responsible for the following:

- Assure statutory and regulatory compliance
- Maintain the storage and distribution of healthcare records
- Ensure compliance with HIPAA and Medicare guidelines
- Manage and implements the Compliance Program
- Monitor Fraud, Waste and Abuse
- Provides report to CMS

Directors/Managers of each function and the Vice President, Compliance, Chief Operating Officer and Chief Financial Officer oversee administrative functions.

MOC 2.A.2 Describe the clinical staff's roles and responsibilities, including oversight functions.

Health Net has an internal integrated care team comprised of clinical and non-clinical staff with knowledge of and experience working with members who have complex and chronic disease and who are dual-eligible . This includes knowledge of Medicare and Medicaid. The team consists of employed and contracted staff responsible for performing clinical functions. Clinical leadership has oversight of the Medical Management (CM, UM, DM) and Quality programs. Our care team, includes licensed physicians, registered nurses, licensed social workers, pharmacists and other healthcare professionals. Members of the these disciplines may also be on Interdisciplinary Care Team (ICT), which is involved in the planning, provision and monitoring of the member's care and services. The following are descriptions of clinical functions performed by Health Net's staff.

VICE PRESIDENT MEDICAL MANAGEMENT

Registered Nurse

- Oversee clinical and administrative staff
- Direct and coordinate activities of the medical management department and aids the appropriate corporate staff in formulating and administering organizational and departmental policies
- Review analysis of activities, costs, operations and forecast data to determine department progress and staffing requirements to meet stated goals and objectives
- Serve as a member of management committees on special studies
- Administer and ensure compliance with National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, state and other activities, meetings and seminars

- Participate in provider education and contracting, as necessary
- Develop departmental objectives and organize activities to achieve success
- Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy, objectives and policies
- Manage, budget and forecast in support of strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices
- Analyze statistical utilization data on programs
- Participate in NCQA, state and/or other accreditation processes
- Ensure compliance of SNP MOC training at hire and annually thereafter for clinical staff
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers, such as hospitals and state agencies, as required to facilitate plan goals and objectives and to ensure the appropriate use of clinical practice guidelines and integrate care transition protocols
- Coordinate with Medical Director to educate and communicate expectations with oversight of appeal and grievance operations

DIRECTOR OF MEDICAL MANAGEMENT

Knowledgeable on Medicare regulations and special needs populations, in addition to being a Licensed RN or Nurse Practitioner

- Oversee clinical and administration of care management services provided to Medicare members including SNP
- Develop department objectives and organizes activities to achieve objectives
- Evaluate and implements changes to medical service functions and performance in relation to company mission, philosophy, objectives and policies
- Manage budget and forecast for strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices
- Analyze statistical utilization data on programs
- Participate in NCQA, State and/or other accreditations of the plan
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers such as hospitals and State agencies, as required, to facilitate the SNP plan goals and objectives
- Coordinate with Medical Director to educate and communicate expectations with providers
- Oversight and management of case management staff and activities

BEHAVIORAL HEALTH MANAGER (PRACTITIONER)

Masters or Doctoral degree in a behavioral health (BH) field and five to seven years of related experience

- Oversee clinical and administrative staff
- Implement, monitor and direct the behavioral health care aspects of Health Net's Care Management and Service Coordination services
- Participate in care management and service coordination rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care serves as the liaison between Health Net and the BH-MCOs

DIRECTOR QUALITY IMPROVEMENT

Licensed RN or Nurse Practitioner, Master level

- Oversee clinical and administrative staff
- Support corporate initiatives through participation on committees and projects
- Develop, review and implement QI activities in coordination with Medicare and State requirements
- Develop, implement, analyze and report Quality Improvement Projects (QIP) and Chronic Care Improvement Projects (CCIP) for the SNP population
- Analyze results of studies and initiate quality improvement projects/initiatives
- Evaluate and recommend performance improvement initiatives and program or process changes to all functional areas
- Research and incorporate best practices into quality improvement initiatives
- Monitor activities to maintain compliance with NCQA accreditation standards
- Coordinate development, documentation and implementation of the QI Program, QI Program Evaluation, and Work Plan including SNP Quality Improvement Program
- Oversee day-to-day operations of the QI Department (QI, Credentialing)

MEDICAL DIRECTOR

Physician who holds an unrestricted license to practice medicine in the state of California and is Board Certified with experience in direct patient care and long term care

- Oversee clinical and administrative staff
- Serve as a clinical resource for CM and members' treating providers
- Work with providers to ensure providers use nationally recognized clinical protocols developed by professional specialty groups or federally funded research (e.g., National Guideline Clearinghouse, Agency for Healthcare Research and Quality (AHRQ), American Medical Association (AMA), etc.)
- Participates in multi-disciplinary rounds on a regular basis to discuss, educate and provide guidance on cases as needed
- Monitor peer-reviewed medical journals to infuse research supported system and practices into Managed Health Service's care management model

- Provide a point of contact for providers with questions about the care management and service coordination processes
- Communicate with practitioners as necessary to discuss care management and service coordination issues
- Review and processing of clinical appeals

PHARMACY DIRECTOR - ENVOLVE PHARMACY SOLUTIONS (PBM)

Registered Pharmacists with active license and clinical expertise

- Oversee clinical and administrative staff
- Ensures compliance with pharmacy requirements and guidelines

CLINICAL PHARMACIST- ENVOLVE PHARMACY SOLUTIONS (PBM)

Registered Pharmacists with active license and clinical expertise

- Ensures there is a consolidated pharmaceutical therapy plan, in conjunction with the members' provider
- Provides member outreach to improve pharmaceutical outcomes as needed to address and try to resolve drug related problems (medication adherence, interactions, etc.)

CARE (CASE) MANAGER II (CM)

Licensed RN (May also hold Certified Care Manager credential)

- Oversee clinical, non-clinical and administrative staff
- Manage SNP members, in particular, those belonging to the most vulnerable populations and requiring LTSS services
- Identify needs and create a care plan, with the help of the member and provider, to help the member achieve their goals
- Support ongoing member engagement with an appropriate medical home
- Address the member's individual needs, strengths, preferences and goals
- Educate members on their conditions and promotes self-management skills including the understanding signs and symptoms that indicate a need to contact the PCP, and when it is appropriate to seek urgent or emergent care
- Support medication adherence
- Engage in member-centric discharge planning
- Ensure timely initiation of post-discharge services and care
- Link members to available community supports
- Coordinate with the behavioral health care managers and providers as needed for members receiving services through the BH MCO
- Communicate and coordinate with the member and their caregivers, practitioners, behavioral health providers, disease management staff and other members of the ICT

to ensure that the member's needs are addressed and care transitions are communicated

MANAGER, MEDICAL MANAGEMENT

Registered Nurse with active license

- Implement changes to medical service functions and performance in relation to Medicare guidelines, company mission, philosophy objectives and policies
- Manage budgets and forecast for strategic planning and key initiatives and balance current future needs effectively
- Research and incorporate best practices into operations.
- Assure compliance of work processes with Medicare Advantage and CMS regulations.
- Responsible for the statistical analysis of utilization data.
- Participates in NCQA accreditation of the Plan.

PROGRAM SPECIALISTS SOCIAL WORKERS (MSW)

Licensed Master's prepared social worker with a background in social services or other applicable health related field

- Works under direction of CM, performing member outreach and care coordination of dually eligible members
- Identify and facilitate access to community resources and social services coordination
- Advocate for the members
- Provide education on benefits and available social services
- Arrange for member transportation
- Assist the CMs in discharge planning and/or transitions to another level of care

PROGRAM COORDINATOR (PC) I

Non-clinical staff person working under the direction and oversight of a CM II.

- Provides administrative support to CC/CM team.
- Collects data and/or completes Health Risk Assessment.
- May participate in providing information to CM II for care plan.

PROGRAM COORDINATOR (PC) II

Highly trained, non-clinical staff person working under the direction and oversight of a CM II.

- Collect data and/or complete for Health Risk Assessment and other surveys
- Supports Manager in operation processes of SNP membership

BEHAVIORAL HEALTH CARE MANAGERS

Licensed Master's or doctoral level clinician with degree in social work, psychology, or related field or equivalent experience with 3+ years of experience in a social service or health care related setting

- Complete BH assessments with member/caregiver/provider to obtain information regarding client status, functional, cognitive capabilities, support system and need for services
- Coordinate chronic condition, disease and health management services
- Monitor delivery of services and follow-up with members/caregivers/providers through member face-to-face assessments and/or reassessments
- Authorize and coordinate referral for services
- Ensure provider services are delivered without gaps and identify functional deficiencies in plans of care
- Assist in coordinating the development of informal or voluntary services to integrate into the ICP
- Collaborate with discharge planners, physicians and other parties to ensure appropriate discharge plan
- Conduct reassessment and update the ICP
- Coordinate acute care, behavioral health, and other services for members

CONCURRENT REVIEW NURSE (RN CASE MANAGERS)

Licensed RN, LPN or LVN

- Manage and monitor member's inpatient staff in coordination with the CM and member's PCP to facilitate discharge arrangements
- Review and audit patient charts through on-site and telephonic review to ensure medical necessity and appropriate level of care
- Act as clinical resources to referral staff and make appropriate referrals
- Provide patient and provider education
- Enter data related to assessments, authorizations and reviews into the system
- Review and audit patient charts through on-site hospital visits

MEMBER CONNECTIONS REPRESENTATIVES

- Perform member outreach, education and home safety assessments
- Assist with community outreach events such as health fairs
- Participate on the Integrated Care Team

MEDICAL MANAGEMENT TRAINER

- Train all Medical Management staff
- Provide support to Provider Relations department on training and education of providers
- Provide training on systems and applications
- Provide further CM training support as requested

PHARMACY TECHNICIAN ENVOLVE PHARMACY SOLUTIONS (PBM)

- Receive and respond to provider/member and pharmacy calls regarding the prior authorization and formulary process
- Intake of complaints and grievances related to the pharmacy prior authorizations

SR. DIRECTOR OF MEDICAL MANAGEMENT

- Develop department objectives and organize activities to achieve objectives
- Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy objectives and policies
- Manage budget and forecast for strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices.
- Responsible for the statistical analysis of utilization data on programs
- Participate in NCQA, State, and/or other accreditations of the Plan
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers such as hospitals and State agencies as required to facilitate plan goals and objectives
- Coordinate with Medical Director to educate and communicate expectations with providers

MOC 2.A.3 Describe how staff responsibilities coordinate with the job title.

Health Net develops, reviews, approves and maintains role based job descriptions for every employee. These job descriptions create the foundation for all training, supervision, monitoring and feedback regarding employee performance. Job descriptions include roles and responsibilities, reporting structure, education and licensing requirements, as well as the skills and competencies necessary to effectively perform in the position. Initial orientation and training includes a detailed review of the individual's job description. Annual performance evaluations includes an assessment of the employee's performance compared to expectations delineated in the job description.

The organizational charts at the end of this document summarize how Health Net integrates administrative and operational oversight with clinical care coordination for members.

MOC 2.A.4 Describe contingency plans used to address ongoing continuity of critical staff functions.

Health Net has a contingency plan to avoid a disruption in care and services and ensure continuation of critical services for SNP members when existing staff can

no longer perform their roles and meet their responsibilities. If administrative or executive staff is unable to fulfill their roles, resources are diverted among corporate or regional offices within the Health Net network.

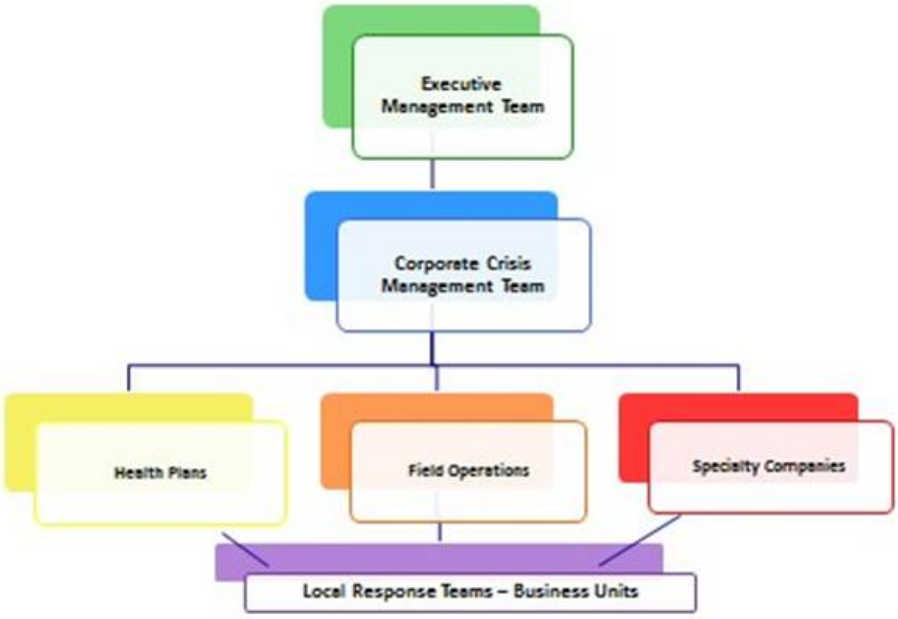
In the event of an absent employee, clinical employees are cross-trained and assigned to ensure continuity of operations, which equates to staff members having one successor. Additionally, remote access is available to Health Net's applications for clinical staff if they cannot commute to the office due to a natural disaster or other impediments. Remote access consists of a web-based program on a secure network. Ultimately, remote access allows staff to continue services securely despite their physical location.

In the event of a natural disaster or an emergency, Health Net immediately implements Centene's business continuity plan, which involves diverting calls and services to other regional health plans within the Centene network. This plan ensures continuity of care and service for our members. Due to the sensitive nature of business continuity plans, the information below is a general overview.

Hierarchy for Decisions

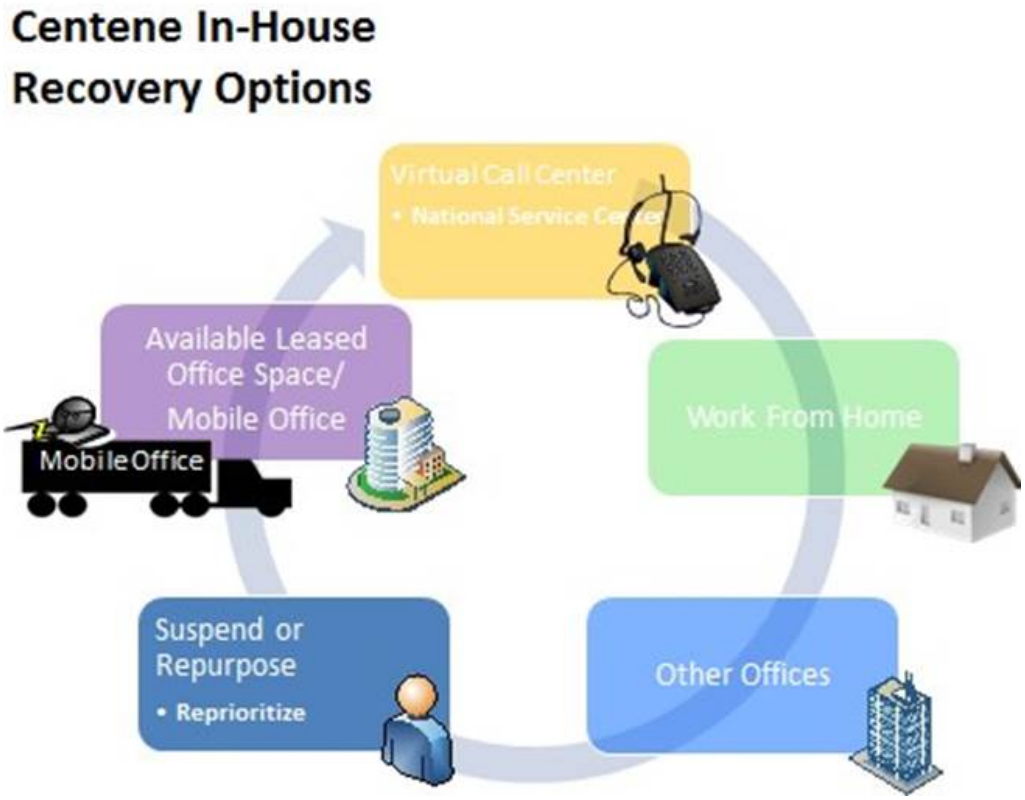
The local business units are organized into a local crisis response team. In the event of a disaster, the local response teams utilize the support of the Centene Crisis Management Team in St. Louis. The Corporate Crisis Management Team reports to Health Net's Executive Management Team.

Business Continuity Governance



Chain or Recovery Options

Options include forwarding Call Center calls to the National Service Center, employees working from home if viable, utilizing other offices within the same State or other Health Net resources throughout the corporation, suspending or repurposing employees to assist as needed, and/or declaring a disaster with our recovery contractor to bring in mobile office trailers, or locate brick and mortar office space through Real Estate Investment Trusts (REITs). One or all of these measures are activated to maintain operations.



MOC 2.A.5 Describe how the organization conducts initial and annual MOC training for its employed and contract staff.

Health Net requires that employees involved with the SNP program undergo SNP MOC training within 90 days of hire, annually, and on an ad hoc basis when circumstances warrant (e.g., policy change, need for improvement, coaching). The Health Net Compliance Officer, in conjunction with the VP Medical Management, are responsible for the oversight of the delivery of initial and annual web-based MOC training.

Additional mandatory training modules includes information on:

- Compliance Program
- Fraud, Waste and Abuse
- Code of Conduct
- HIPAA
- Cultural Competency
- Conducting administrative activities necessary for the operation of the Part D benefit
- Medicare Marketing

- Marketing the prescription drug benefit to Medicare beneficiaries
- Medicare Member Eligibility
- Medicare Medical Management Training:
    - Medicare Overview Medical Management Operations
    - Medicare Utilization Management Process
    - Medicare Model Of Care
    - Medicare Guidance on Coverage Policy
    - Medicare Jimmo v. Sebelius
    - TruCare Training (electronic medical management system)
    - InterQual Training
- Customer Service and Call Center Operations Standards
- Appeals and Grievance Process
- Administering the compliance program and operations, i.e., the Part D Officer and his/her staff
- Business Ethics and Conduct policy and other compliance related policies, procedures, standards

Health Net's SNP Model of Care training includes informational and interactive slides that cover MOC topics such as: Goals of the MOC, SNP population, Provider network, Additional benefits, Case Management, HRA, ICP, ICT, Care transitions, Coordination of Medicare and Medicaid, and the Quality Improvement Program. A sample from the training slides is included on the next page:

Special Needs Plans (SNPs) Model of Care

Annual Training

Presentation For:
Employees

Cornerstone
2017

Health Net

Health Net

Special Needs Plan (SNP) Background

SNPs were created as part of the Medicare Modernization Act in 2003. Medicare Advantage plans must design special benefit packages for groups with distinct health care needs, providing extra benefits, improving care and decreasing costs for the frail and elderly through improved coordination:

- Dual Eligible or D-SNP for members eligible for Medicare and Medicaid
- Chronic Disease or C-SNP for members with severe or disabling chronic conditions – an initial attestation that patient has specific condition is required from provider
- Institutional or I-SNP for members requiring an institutional level of care or equivalent living in the community

There are 3 distinct types of SNPs.

2

Health Net

Health Net SNPs

Health Net has two types of SNPs:

- **D-SNPs** for members that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- **C-SNPs** for members with chronic and disabling disorders known as the Jade SNPs - one or more of the following chronic diseases is required depending on the specific plan:

1. *Diabetes*
2. *Chronic Heart Failure*
3. *Cardiovascular Disorders:*
   - Cardiac Arrhythmias
   - Coronary Artery Disease
   - Peripheral Vascular Disease
   - Chronic Venous Thromboembolic Disorder

3

Health Net

Benefits to Meet Specialized Needs

- **Decision Power Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation** – these benefits vary by region and type of SNP

SNPs provide additional benefits for members

4

Health Net

Patient Centric

- Patient is informed of and consents to Case Management
- Patient participates in development of their Care Plan
- Patient agrees to the goals and interventions of their Care Plan
- Patient informed of Interdisciplinary Care Team (ICT) members and meetings
- Patient either participates in the ICT meeting or provides input through the Case Manager and is informed of the outcomes
- Patient satisfaction with the SNP Program is measured annually

5

Health Net

Evidence Based Case Management (CM)

- All SNP patients are enrolled in case management and notified of their Case Manager single point of contact by letter/follow-up phone call
- Patients may opt out of active case management but Case Manager continues to attempt an annual contact or when change in status or transition in care.
- Patients are stratified according to their risk profile and Health Risk Assessment (HRA) to focus resources on most vulnerable (frail, disabled, chronic diseases)
- Patients with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive primary case management from MHN, Health Net's Behavioral Health provider
- Contingency planning is in place to avoid disruption of services for events such as disasters

6

Health Risk Assessment (HRA)

- An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Health Net attempts to complete initial HRA telephonically within 90 days of enrollment and annually or if there is a change in the patients condition or transition of care
- Multiple attempts are made to contact the patient including mailed surveys and e-mail reminders
- The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail
- Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan

Completion of the HRA is also a Star Measure.

7

The ICP Addresses All Risks identified in the HRA and/or Other Sources

HRA/Assessment/Claims	Risks
Medical History Gap Reports Utilization Reports	Diabetes Obesity Lack of medication adherence Recent ER visit for fall
Labwork/ biometrics	HgA1c - 9 BMI – 31
Mental Health	Positive depression screen
Health Behaviors	Does not get annual Flu vaccine
Psychosocial	No transportation to Dr. appts

8

Goals are Specific, Measureable and Include Date

Risk	Specific and Measurable Goal Established with Patient
Poor Medication Adherence	Patient will report taking diabetes medications daily at each monthly call and will not be on care gap list by March.
Positive Depression Screen	Patient will report discussing emotional health with PCP at next doctor appointment on April 20th.
Obesity – BMI	Patient will lose 5 pounds over next 6 months
Fall Risk	Patient will report going to gym once per week during monthly calls
Lack of Annual Flu vaccine	Patient will get flu vaccine by November 1.
Lack of transportation	Patient will successfully utilize transportation benefit for next doctor appointment on April 20th

A goal is identified for each risk.

9

ICP Includes Actions to Achieve Goals

Risks	Actions to Achieve Goals
Poor control of Diabetes Obesity Poor medication adherence Recent ER visit for fall	Provide Diabetes and diet education. Set exercise and weight loss goals with patient Review medication regime and provide adherence tips to address individual barriers Fall prevention education and to discuss with doctor
HgA1c - 9 BMI – 31	Monitor lab work and weight for improvement
Positive depression screen	Referral to MHN
Does not get annual Flu vaccine	Educate on importance of vaccine, address barriers to obtaining vaccine
No transportation to Dr. appts	Educate on benefit and provide contact information

10

Implementation of the ICP is Documented

Goal	Case Manager Notes
Poor Control of Diabetes	*Reviewed diet with patient – she reports eating smaller portions since last call and diet education.*
Poor Medication Adherence	*Review of diabetes medications and proper admin– patient verbalizes understanding. Encouraged to use pill box.*
Positive Depression Screen	*Patient refused referral to MHN – states she will discuss with her doctor at April visit.*
Obesity – BMI	*Patient states she only lost 2 lbs at Doctor visit yesterday. Reviewed concept of steady and slow weight loss.*
Fall Risk	*Patient reports she is taking 15 minute walk once a day and will increase to 20 minutes next week.*
Lack of Annual Flu Vaccine	*Review of importance of Flu vaccine – patient still concerned it will make her sick. Addressed barriers.*
Lack of Transportation	*Patient has contacted transportation company and arranged ride to 4/20 Dr. appointment*

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Interdisciplinary Care Team (ICT)

The Health Net, MHN or delegated Case Manager coordinates the ICT which communicates regularly to manage the patient's medical, cognitive, psychosocial and functional needs. The patient and/or caregiver is included on the ICT whenever possible:

- Required Team Members

Medical Expert
Social Services Expert
Mental/Behavioral Health Expert – when indicated

- Additional Team Members could be

Pharmacist
Health Educator
Restorative Therapist
Nutrition Specialist
Nursing/Disease Management

- Communication plan for regular exchange of information within the ICT including accommodations for members with sensory, language or cognitive barriers

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Care Transition Protocols

Good transitional care is key to decrease readmissions.

Patients are at risk of adverse outcomes when there is transition between settings (in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers or home health)

- Patients experiencing an inpatient transition are identified and managed (pre-authorization, facility notification, census)
- Important elements (diagnoses, medications, treatments, providers and contacts) of the patient's care plan transferred between care settings before, during and after a transition
- Patient knows their health information and can communicate to other healthcare providers in different settings
- Patient is educated about health status and self-management skills: discharge needs, meds, follow-up care, signs of change and how to respond (discharge instructions, post-discharge calls)

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Specialized Provider Network

- A comprehensive network of primary care providers and specialists such as cardiologists, neurologists and behavioral health practitioners is provided to meet the health needs of chronically ill, frail and disabled SNP patients
- Team based case management is provided internally when it is not delegated to the patient's primary care provider and medical group
- Delegated medical groups must demonstrate capability to meet the team based care requirements
- The Delegation Oversight team conducts audits to monitor that delegated medical groups meet the SNP Model of Care requirements

Providers are also required to complete Model of Care training.

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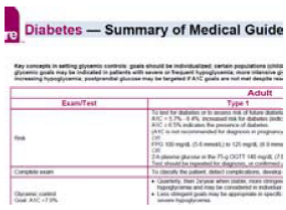
Jade C-SNPs – Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Diabetes, the program offers:

- Disease Management to assist patients to manage their Diabetes
- Interactive programs for healthy activity and weight control
- Additional benefits (vary by plan) can include zero cost for Diabetic monitoring supplies, low cost Podiatrist visits
- Clinical Practice Guidelines for Diabetes and other chronic diseases located on the Provider Portal


Diabetes — Summary of Medical Guide

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D-SNPs -Coordinating Medicare and Medicaid

The goals for coordination of Medicare and Medicaid benefits for members that are dual-eligible:

- Members are informed of benefits offered by both programs
- Members are assisted to maintain Medicaid eligibility
- Member has access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and Medicaid

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Quality Improvement Program

Health Plans offering a SNP must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met
- Collecting SNP specific HEDIS® measures (see appendix)
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the SNP population
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness.
- Communicating goal outcomes to stakeholders

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Care Management and Service Coordination Staff Training

Care Management and Service Coordination staff receive, at time of hire and annually Medicare Boot Camp Training that includes, but are not limited to the following:

- Care Management and Service Coordination policies and procedures and regulatory requirements
- Member-Centered Care Planning
- Care Manager / Care Coordinator roles and responsibilities
- Motivational interviewing and readiness to change techniques
- Medicare Assessments
- Member Outreach
- Documentation
- ICP and ICT Processes
- Care Transitions
- Provider Relations
- Member Outcomes
- Care Management and Service Coordination (including appropriate documentation of tasks in TruCare)
- Behavior management strategies
- Behavioral health 101
- De-escalation techniques

Training to Ensure Coordination of Benefits. Staff receive Medicare/Medicaid specific training that describes how the programs intertwine and their specific roles and responsibilities when a member is enrolled in the SNP:

- Coordination and management of dual Members
- Specific characteristics of the population
- Services to meet specialized needs
- Medicare and Medicaid covered benefits
- Engagement techniques

In addition, training may be conducted to cover regional variances and/or specific indicators and/or needs of different areas of the state. Health Net measures effectiveness of education/training provided through audits and individual assessments. All trainers update materials as soon as new information and updated components become available.

Continuing education is provided to CM staff to support clinical competency as well as communication skills. Our Cornerstone web learning is available for both required and optional topics, and we provide lunch and learn opportunities for CM staff.

Methods for Delivering Training is provided using one or more of the following methods:

- Face-to-face training via a preceptor
- Peer shadowing
- Web-based interactive training
- Group led training
- Telephonically
- Self-study through the use of print materials and electronic media (i.e., Centene's Cornerstone library of training classes)

Coordination of Benefits and Dual Appeals and Grievance Training. The Managers of Medical Management and Trainers provide additional training specific for integrated care team staff regarding coordination of Medicare/Medicaid, Members rights and responsibilities, appeal and grievance policies, procedures and processes.

MOC 2.A.6 Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.

Employees and contracted staff completion of class room trainings, group led training, and on-line MOC training is documented and maintained via *Cornerstone*, an internal web-based educational database that efficiently tracks training completion. Through *Cornerstone*, the Compliance Officer and the VP Medical Management are able to track and review completion of training.

The appropriate department Directors, Managers, and Supervisors are responsible for oversight of the SNP Model of Care training for their respective departments and associates. In addition to monitoring employee completion of the initial and annual training requirements, they are responsible to provide training on individual responsibilities related to the implementation of department specific components of the SNP Model of Care. This training may be offered in a classroom, teleconference, or self-study environment as appropriate.

MOC 2.A.7 Describe actions the organization takes if staff do not complete the required MOC training.

If it is identified that an employee failed to complete MOC training, the employee and the employee's supervisor are notified and the employee is instructed to complete the course immediately. For those who fail to complete required MOC training after the first attempt of remediation, disciplinary actions are administered in accordance with Health Net's Human Resources discipline policy.

Challenges with employed and contracted staff completing the SNP MOC training include the time taken away from the regular workday to complete the training, repetitiveness of annual

training and time for managers to monitor that training is completed. To address these issues, the training is updated regularly, is interactive and informative and can be completed in a reasonable amount of time. The tracking system allows managers to run reports showing any associates that have not completed the training.

MOC 2.B HEALTH RISK ASSESSMENT TOOL (HRAT)

MOC 2.B.1 How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary.

Health Risk Assessment Tool (HRAT). The Health Risk Assessment (HRA) tool is an internally designed tool developed to identify the needs of SNP plan members by evaluating medical, psychological, functional, environmental, social and cognitive needs. The assessment also gauges the member's medical and mental health history to effectively coordinate care and identify any barriers that should be addressed to improve care outcomes. The HRA generates the initial list of problems based on the member's self-reported data, and based on a scoring methodology, determines the level of severity/risk.

Member Engagement and Initial Assessment. For the initial screening, the Vendor staff contacts the member to conduct the HRA within 90 days of the member's effective date. If vendor contacts are unsuccessful the Care Team conducts at least three phone attempts made at different dates and times to engage the member. All outreach attempts (successful or unsuccessful) are documented in a Care Management/Service Coordination Outreach note in the clinical documentation system (TruCare). When CM or other staff call members for other purposes and notice that the HRA has not been completed, they attempt to complete the assessment. Members unable to be contacted via telephone are mailed a letter requesting that they call the care management team. Outreach continues to complete the assessments of those members unable to be reached within 90 days. CM staff research available information such as claims, pharmaceutical, providers for additional contact information when unable to reach member.

Risk Stratification and Development of ICT. Once the HRA is completed, reviewed and scored, the CM updates the ICP. The CM, based on the initial HRA results, assists the member in choosing the members of their Interdisciplinary Care Team (ICT). The member may include, their PCP and any healthcare professionals and other support individuals of their choice. The ICT helps develop the Individualized Care Plan (ICP). If the HRA not completed, CM reviews other available information such as pharmacy, utilization and claims to complete an ICP for every member.

MOC 2.B.2 How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information.

Sharing the Results of the HRAT with the ICT and Creation of ICP. The CM contacts the member and/or caregiver via phone, the various problems and member goals identified are discussed, treatment and service options are presented to the member/caregiver, and the ICP is developed/updated, which includes goals, interventions and time frames.

Using the HRAT Results to Update the ICP. Annually thereafter, or when the member's conditions or health status changes significantly, such as an inpatient admission or transition to a higher level of care, the HRA is updated by the CM or other assigned staff with CM oversight. Results of the updated HRA are discussed with the members of the ICT. The member and/or caregiver is invited to participate in the ICT meeting, and the ICP is revised and adjusted to reflect member needs and preferences and any changes identified by the HRA. The member retains the right to change who participates on the ICT at any time.

Tools to be utilized are approved and based on our population characteristics.

MOC 2.B.3 How the organization conducts the initial HRAT and annual reassessment for each beneficiary.

Health Net conducts an initial comprehensive Health Risk Assessment (HRA) for each new SNP member to evaluate the individual's physical, psychosocial, and functional needs. An annual reassessment is conducted for each of the SNP member as part of the ongoing care plan evaluation. The HRA assessment can be performed telephonically, electronically or by mail. To achieve this, the following procedures are followed:

- Vendor or case manager performs telephonic outreach to complete the HRA with all new SNP members within 90 days.
- If the member was not reached via telephone after three attempts, the HRA is mailed to the member to complete within the first 90 days of enrollment. A postage paid return envelope is provided to assist the member with returning the information.
- HN Case Managers can also complete the HRA directly into the electronic medical management system if they contact a member who has not completed the HRA or if there is a change in member status
- The vendor is provided in advance with the list of continuing members due for a reassessment HRA so it can be completed within one year of the initial or previous HRA
- HN Case Managers also reach out to members who have refused to participate in case management upon a change in status such as a hospitalization and at least annually to promote case management services and complete the HRA if the member agrees

- Information/data collected from the HRA is evaluated to determine individual members' needs and assists with development of a Care Plan and coordination of care and shared with the Interdisciplinary Care Team members.

The Care Plan and member needs are re-evaluated on a regular basis, such as when the annual HRA reassessment is completed or updated as member health status changes, or a care transition has occurred to ensure that the Care Manager has the most current physical, psychosocial, and functional needs information for effective, timely and continuous patient care coordination.

MOC 2.B.4 The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

Once the initial HRA has been completed, it is updated as needed based on changes to the member's health, functional and environmental conditions, transition in care or increased risk for hospitalization based on information provided through predictive modeling. All assessments are documented in TruCare with date/time stamps for each activity, including documentation of the CM or other staff completing the activity. Each HRA is scored based on an algorithm that weights members' responses and their individual clinical assessment.

Communicating Information to the ICT. Member clinical status, HRA results and other clinical data is shared during the ICT meetings. The ICP is updated based on ICT discussion and includes interventions and goals, and the associated timeframes. The updated ICP may be shared with the member/caregiver face-to-face, verbally by phone or sent via mail.

Using HRAT Results to Improve the Care Management Process. CM frequency of member contact to assess progress with the new ICP is determined by the level of the member's risk score and acuity level. Frequency of contacts is adjusted based on member's preference and progress based on CM clinical judgment.

- High – Including members identified as "most vulnerable"
    - Minimum continuous monitoring and review/outreach every 30 days; or more frequently as needed
    - Completion of an ICP no later than 120 days of enrollment
    - Telephonic reassessment when there is a change in the member's health status or needs, a significant healthcare event, or as requested by the member, his/her caregiver or provider
- Moderate – Identified inpatient and post discharge individuals.
    - Close monitoring during the post discharge period for 30-60 days.
    - Update of the ICP during the 30-60 day period.

    - Telephonic reassessment during the 30-60 days period to consider appropriate re-stratification to High or Low.
- Low – Member is stable but results of the Medicare CM Assessment/HRA indicate risk for a potential complication
    - Minimum continuous monitoring and review/outreach once a year or more frequently as needed
    - Completion of an ICP no later than 120 days of enrollment
    - Telephonic reassessment when there is a change in the member's health status or needs, a significant health care event, or as requested by the member, his/her caregiver or provider

MOC 2.C INIDVIDUALIZED CARE PLAN (ICP)

MOC 2.C.1 Essential Components of the ICP

Person-Centered Care Planning – Health Net's person-centered approach focuses on the member's strengths, needs, preferences and develops individual goals and interventions in collaboration with the member and caregivers. To support the member safely, in the least restrictive setting of choice, CMs work with the member to develop an ICP that identifies barriers preventing the member from managing their current conditions and determines interventions to promote and maintain self-sufficiency.

Essential Elements of the ICP - The ICP includes self-management goals and objectives, a description of authorized services specifically tailored to the member's needs including type, duration, frequency, and provider, timeframe for reassessment, short and long-term goals for health promotion and prevention, referrals and interventions, barriers, the member's personal healthcare needs and preferences, and timeframes for completion.

An ICP typically includes the following:

- Prioritized goals – both short term and long term goals are determined with the member and are specific, measurable, attainable, realistic and timely
- Identification of barriers to meeting goals and person-centered recommended solutions for each barrier including language, cultural/spiritual preferences, literacy (general and health), functional impairments, sensory and/or cognitive impairments, motivation, health disparities, access (geographic location, transportation), and lack of family, caregiver and/or informal supports
- Resources to be utilized, including appropriate level of care and member preference

- Interventions based on the member's identified problems, strengths, resources, barriers and agreed upon goals
- Self-management plans created to support members in managing their health, including specific technology supports, tools, and disease management/health education
- Collaboration with ICT including involvement of family, caregivers, providers and other formal and informal supports
- Schedule for ongoing communication with the member and ICT, based on acuity, needs, preferences and agreed upon goals
- Timeframes and interim outcomes that create points in time for which achievement towards goals is measured, including the specific manner in which progress is demonstrated
- Education provided to the member, family/caregiver including written materials, telephonic or in person education, health coaching, and referral to other available information such as that found on the member/caregiver portals or through community organizations and advocacy groups (e.g. Alzheimer's Association, Brain Injury Association of PA, etc.)

Interventions and Activities Included in the ICP - Interventions and activities may include care coordination for authorization of needed services such as transportation, home health care, equipment, supplies, ancillary services such as physical, occupational or other rehabilitation therapies, and referrals for preventive screenings. They also include health education needs, member self-management activities and goals, and evidence based disease management parameters such as HgbA1c every 6 months and annual dilated eye exam for diabetics. The ICP identifies barriers to achieving goals (financial, cultural, linguistic, lack of family support, cognitive impairments, etc.) and the strategies for overcoming these barriers. Finally, the ICP identifies gaps in care and services that require mitigation and the method for obtaining needed care and service, including collaboration and coordination of care and services provided by other health care and community based organizations, and supports (in-home meals, home repair, falls assessment, in-home support services, etc.). Interventions may include, but are not limited to the following:

- Guiding the member in achieving optimal health through the monitoring of specific clinical indicators
- Coordinating covered and non-covered benefits
- Coordinating inpatient and outpatient services
- Managing transitions in care settings.
- Educating member and supporting self-management activities
- Addressing barriers to care, including access to non-network providers as appropriate
- Assessing outcomes and updating the ICP on a regular basis

- Assisting with referrals to services appropriate for members nearing end of life such as Advanced Directives or hospice care
- Arranging for in-home visits to assess risk for falls and needed accommodations

MOC 2.C.2 Process to develop the ICP including how often ICP is modified as member's healthcare needs change

The member and/or member's caregiver is included in the ICP development whenever possible, and information from the primary care provider, specialists, non-professional caregivers, health records, specialist records and pharmacy data are used to aid in the full development of the ICP. Every member of the ICT aims for ensuring the member and/or his or her caregiver is engaged and empowered within the process and in decision-making. Health Net employees empower members and/or caregivers through education, open communication, and partnership. Such empowerment encourages member and caregiver involvement, engagement and improved success in meeting established goals.

CM as "One Point of Contact" - In the course of developing the ICP, referrals are made, as needed, to the appropriate team members/providers of needed care. For example, if the individual indicated difficulty with housing, utilities, buying food or other financial concerns, the assigned CM would provide linkage to community resources if appropriate, and communicate the results back to the ICT. However, if behavioral health needs are identified, the CM coordinates with the BH providers to ensure a whole person approach towards care management. Wherever possible, the CM serves as the single/one point of contact for the member, but is responsible for introducing to the member and/or their caregiver to any new members of the team prior to any outreach by these individuals. The intent of this outreach is to ensure the member and/or their caregiver is aware of the role this new individual has, along with when they can anticipate outreach/contact. For example, the CM introduces the DM Health Coach in cases where health education and outreach is included as an intervention in the ICP.

Assessment – During the assessment process, the CM collects information about the member's mental and physical condition, functional status, and formal and informal social support system to identify their needs and develop the ICP. In addition to information collected during the assessment, supplemental information is gathered from other relevant sources (i.e. primary care provider, professional caregivers, non-professional caregivers, health records, and educational institutions/records, historical claims data, prior assessment, etc.), which are utilized to further refine the ICP. Ongoing reassessments occur when there is a change in the member's health status or needs, a significant healthcare event, or as requested by the member, their PCP or their caregiver.

Identifying problems **–** The CM asks open- and closed-ended questions to obtain key information. He/she practices active listening to appropriately identify the member's problems.

In order to achieve the best possible health outcome, the CM collaborates with the member, his or her circle of support/caregiver, and the PCP to identify problems and barriers to meeting goals. Examples of identified problems/barriers may include but are not limited to:

- Lack of knowledge about disease process
- Lack of available resources
- Limited or no family support
- Psycho-social needs
- Low literacy/health literacy
- Language and culture
- No transportation or ability to schedule appointments

To overcome barriers and issues, the ICP includes a set of tailored services for each member, which includes preventive health services, preferences for care, chronic disease education, and other accommodations and services. The ICP is intended to increase self-management, independence and improved health status of each member.

Establishing goals – The CM collaborates with the member/caregiver, provider, and ICT members when establishing care plan goals and a member driven self-management plan. The care plan includes the member's preferences and a description of the services tailored to the member's needs. The goals are specific, realistic, individualized and measurable.

- Long Term
- Short Term
- Consult with attending physician, other health care providers, client, family members, guardians etc.
- Obtain member buy-in for effective behavior modification and superior outcomes
- Determine how goals will be achieved and revise goals if necessary
- Be flexible
- Be creative
- Need for authorization
- Are the goals cost effective while maintaining quality of care?

Implementing Interventions – The CM executes specific care management activities and/or interventions to accomplish the goals in the ICP. Selected interventions are usually inclusive of the member's willingness to participate, time sensitive and measurable. For example a CM may do the following:

- Implement a self-management plan which demonstrates:
    - Documentation of the action the member takes to improve the care
    - Documentation of member agreement to perform the action
- Document actions the CM takes in monitoring the ICP to ensure member compliance

- Identify/contract with providers needing to be involved
- Identify services or equipment which are not a covered benefit but may be a cost effective intervention
- Provide education based on health education needs
- Educate on medication
- Reinforce and explain why the member needs to be adherent to treatment plan
- Anticipate any obstacle to meeting treatment goals (e.g., transportation, ability to schedule appointments)
- Establish effective date for start of services
- Contact member and/or caregiver and initiate education and other activities

Evaluation and Reassessment - The CM performs ongoing assessments in order to evaluate the member's progress toward the goals or identify barriers impeding the achievement of such goals. The CM completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year.

Updating the ICP - The CM updates the ICP at least annually, and at the time of a significant change in status (inpatient hospitalization, change in level of care or care setting, etc.) and/or, as needed, in response to other information obtained. Examples could be HRAT re-assessments; information obtained from providers, members and caregivers; claims data that may identify patterns of over or under-utilization including medication non-adherence; and any additional information related to health conditions, functional status, barriers to care, community supports and the member's response to interventions in the existing care. Updates are based on the member's status, needs, and preferences including cultural and linguistic preferences. The CM and ICT rely upon evidence-based practices in developing appropriate interventions.

Changing Risk Categories - For example, a member who is stratified as low risk but has an admission, new diagnosis, or increased utilization is reassessed to determine if there are changes in his/her health and/or and functional status that require him/her to be placed at a higher risk level with associated adjustments in the ICP. Members may temporarily move to a higher risk level during an acute phase of care (i.e. a member who has elective joint replacement surgery with full recovery) or from a higher level to a lower level as their health and functional status improves as a result of attaining self-management goals (i.e. a member with diabetes achieves stable blood glucose levels through medication adjustments and improved dietary habits). This often leads to a modification or change in the care management/care coordination plan in its entirety or in any of its component parts, as follows:

- Determine if treatment ICP goals have been attained (the goals are evaluated and refined based on member acuity)
- Measure member/caregiver/significant other's satisfaction with services

When goals are not met, the CM reassesses the member's situation and functioning as described above. The CM contacts the PCP and other members of the ICT as needed to discuss modifications and obtain an updated medical treatment plan. Based on the findings, the Care Manager provides supplemental resources or modifies the goals. The CM engages the member, communicates any changes in the ICP to the member and other members of the ICT, and providers, as needed, via phone, email, mail, and fax and documents this in TruCare.

MOC 2.C.3 Personnel responsible for development of the ICP including member/caregiver involvement

The assigned CM is responsible for the development of the ICP, in collaboration with the members and/or their family/caregiver, and the members of the ICT. CMs may be assigned high, moderate or low risk members. High risk BH members may be assigned to BH CMs that can best meet their needs.

The CM continuously attempts to engage the member/designee and provider(s) in care planning discussions related to goals, preferences, activities and interventions. Our CM is trained in motivational interviewing and member engagement strategies in order to maximize member engagement in care planning. Copies of the ICP are provided to the member/designee and PCP upon request and the document is used to guide discussion during telephonic contacts. Our goal is for the individual care plan to be a "living document" that provides a framework for managing the member's care and services. As a member's needs and preferences evolve over time, the care plan, along with the composition of the Integrated Care Team, also evolves and changes.

MOC 2.C 4 Documentation, updating and maintenance of the ICP

Documentation -All documentation of assessments, ICP and related follow-up communications are captured and updated in TruCare, our clinical documentation system. This system is only accessible by Health Net staff; however, the ICP is shared via facsimile/mail/telephone to the primary care providers. Member records are maintained in accordance with HIPAA, state and federal privacy laws and professional standards of health information management.

Oversight - The CM is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers or other involved parties. The information available in TruCare includes, but is not limited to the following:

- Notes, including a summary of team conferences and all communications with the member/family, healthcare providers and any other parties pertaining to the member's care
- Physician treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available

- Facility admission information and discharge plans
- MemberConnections outreach attempts to connect with a hard-to-reach or unable to locate member
- The ICP, including:
    - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - The member's self-management plan
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc.

Using Evidence Based Criteria - The CM is trained in the Medicare, Medicaid benefits, and supplemental benefits offered to the most vulnerable SNP population. Training enables the CM to facilitate care for the member through the prior authorization process and educating the member as to available benefits and community services and other supports. CMs have access to evidence-based clinical resources to help determine standards of care for this population. Health Net provides the following resources of medical criteria:

- InterQual® Care Planning Procedures Criteria
- National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) policies for Medicare Part A & B services
- Clinical coverage and practice guidelines

Communicating Changes in Member Status to the ICT - The CM is in a unique position to know and understand all facets of the member's condition and abilities. It is the responsibility of the CM, as a member of the ICT, to inform other team members about any changes in the member's health status so that the team is able to track the progress of the ICP and make any modifications needed to improve outcomes or support a member during a significant health event or transition in care.

Reviewing, Analyzing and Updating the ICP - The ICT, as the on-going evaluation of the ICP occurs, continues to change in order to include other members so as to ensure the member has access and coordination of all needed care. The ICT, led by the CM, are responsible for reviewing, analyzing and revising of the care plan with a multi-disciplinary focus. The ICT also considers alternatives for health care delivery, available funding options, and other methods to help the member progress.

The ICP is reviewed and modified by the CM for any significant life/health event as needed, but no less than annually after the initial assessment. Modifications involve the entire ICT, including the member and/or their caregiver. The CM or a member of the ICT team completes the ICP changes after the review and with the assistance of the full ICT, and with the involvement of the member or member's caregiver. The PCP's input is critical as well.

Life/health events may include recent new diagnoses or complications of prior diagnoses, recent hospital stays, caregiver changes, living arrangement changes, or even financial changes. Revisions need to be reasonable, understood and accepted by the member and/or their caregiver to encourage full and active participation with the ICP.

MOC 2.C.5 Communication of updates and modification of the ICP to members and stakeholders

Members and their caregivers are engaged in any changes to the ICP and providers are notified anytime there is a change in the ICP. Communication may be verbal or in writing. All communication is documented in TruCare.
ICP communications may occur in a variety of formats based on the member's care coordination needs including, but not limited to:

- Face-to-face meetings – Internal or external meeting with caregivers (with or without other members of the ICT, such as a home health care nurse, or members of our internal integrated care team)
- Telephonic – Direct calls with member/member's representative and/or providers
- Case reviews/rounds - Internal meetings with ICT

MOC 2.D INTERDISCIPLINARY CARE TEAM (ICT)

MOC 2.D.1 How organization determines composition of the ICT

Health Net has an Integrated Care Team (ICT), which may utilize Program Specialists, Care Managers, Pharmacy Coordinators, Behavioral Health Coordinators, Program Coordinators, Member Connections Representatives, pharmacists and Medical Directors. The external team is comprised of primary care providers, specialty care providers, behavioral health providers, ancillary services, community based organization representatives, faith-based representatives, various state agencies, and other members as appropriate to the member's needs and preferences. The member is invited to participate as well.

ICTs are generally comprised of multidisciplinary clinical and nonclinical staff and are led by CM with support by Medical Directors. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, which permits the licensed professional staff to focus on the more complex and clinically based service coordination needs, works closely with the utilization management staff to coordinate care when members are hospitalized and assist with discharge planning and prior authorization activities. The teams utilize a common clinical documentation system to maintain centralized health information for each member, which includes medical, behavioral health and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated, based on severity and complexity of the member's needs**.**

The following are the individuals who are involved in the Care Management functions performed by Health Net:

Medical Director The Medical Director oversees the care management program and ICTs and is responsible for managing the medical review activities pertaining to care and service coordination, utilization review, quality improvement, complex, investigational and/or experimental services. The Medical Director assures that providers use and adhere to appropriate clinical practice guidelines and integrated care transition protocols. In conjunction with the Vice President of Medical Management, the Medical Director evaluates the effectiveness of the care management and care coordination programs at least annually.

Vice President of Medical Management The Vice President of Medical Management is responsible for the day-to-day operations and clinical oversight of the care management program including compliance and preservation of MMP medical information in accordance with HIPAA and contractual requirements. The Vice President of Medical Management monitors the provision of services to assure there is a seamless transition of care across settings and providers and that clinical services are appropriate and timely. These functions are accomplished by regularly occurring audits and random attendance at ICT meetings.

Care Managers Care Managers (CM) are experienced RN case managers (preferably with CCM certification). CMs establish and implement the ICP/ICT for D-SNP members not receiving LTSS, coordinate team activities to ensure that needed care and services are provided, outreach to obtain authorization for necessary care services, educate members on self-management techniques, and provide ongoing assessment of the member's response to care and services. CMs work directly with the member and his/her support system to achieve an optimal level of health and function. They hold a key position in the ICT.

Program Specialists Masters prepared social workers are responsible for the identification and facilitation of access to community resources and social services coordination for D-SNP members not receiving LTSS services. They hold a vital membership position on the ICT. Social workers advocate for the members, provide education on benefits and available social services, make arrangements for member transportation, and assist with discharge planning.

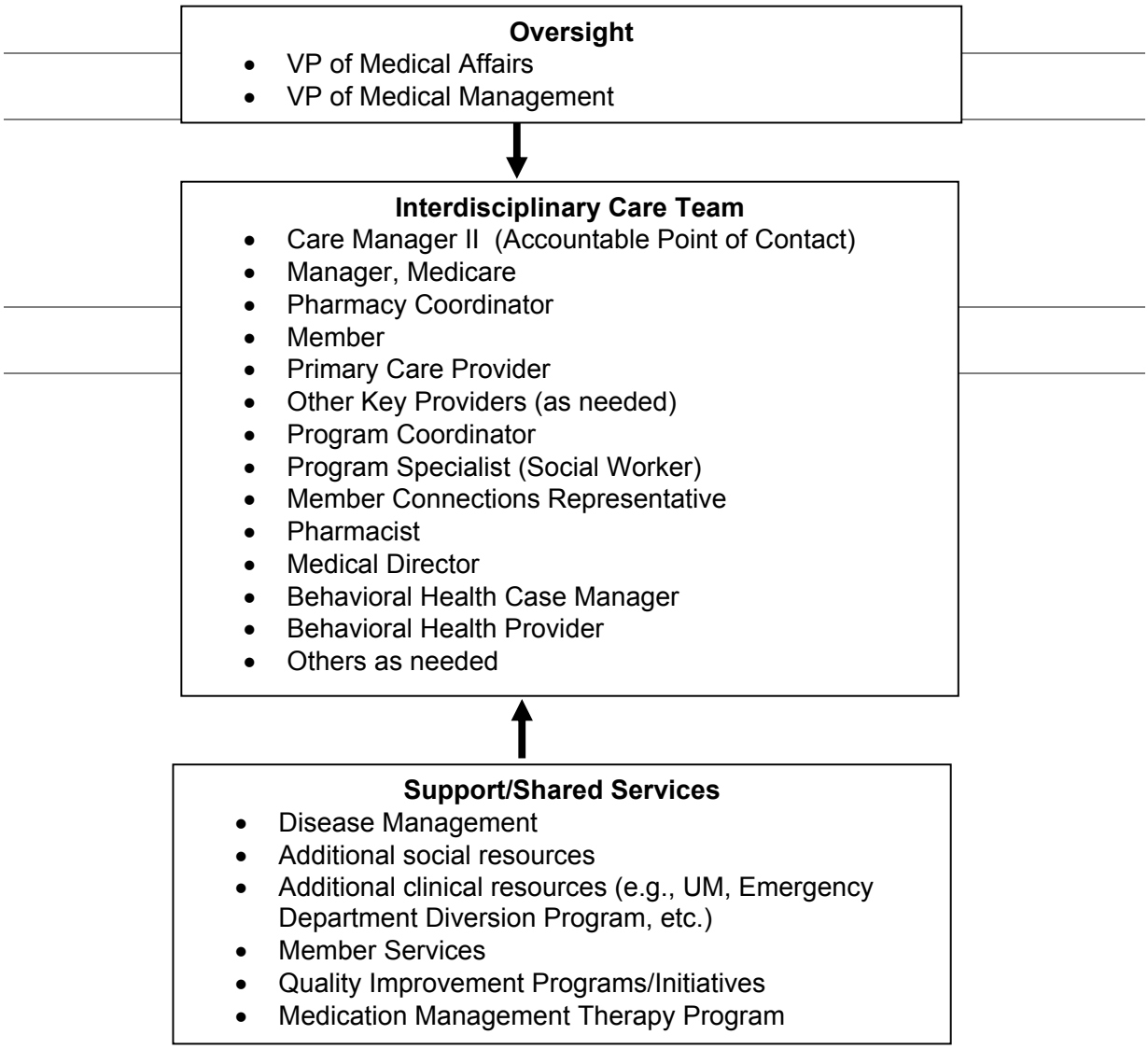
Program Coordinators The Program Coordinators have administrative and clinical support experience and are utilized to collect member and/or provider demographic information, completing data entry, establish case files, coordinate non-clinical services and provide administrative support to the team as needed. Program Coordinators may also assist the CM in scheduling appointments and following up on services for the D-SNP member.

Behavioral Health Case Manager The Behavioral Health Case Manager is the team member with the primary responsibility of ensuring behavioral health needs are identified and addressed. In addition to participating on the ICT, the Behavioral Health Case Manager also

attends the integrated care management rounds to facilitate identification of behavioral health issues for D-SNP members.

Pharmacist/Pharmacy Coordinator The pharmacist and/or pharmacy coordinator, in conjunction with the member's provider, ensures there is a consolidated pharmaceutical therapy plan, identify drug interactions, minimize side effects, and work with the D-SNP members to establish a pharmaceutical therapy program.

Utilization Review (UM/CM) Nurses/Manager The Utilization Nurse/Case manager (RN) reviews the appropriateness of medical service requests to promote efficiency and maximize allocation of resources. The manager provides operational and administrate oversight to this department.



The Medical Director and the Vice President of Medical Management are responsible for articulating a clear vision for Health Net's Care Management and Care Coordination Programs and ensuring the appropriate Health Net staff is available to participate in the ICT.

Challenges around member access to providers, care and/or services are communicated directly to Provider Services. The Director of Medical Management is responsible for semi-annual review and reporting of ICT activities to the Utilization Management Committee (UMC).

Interdisciplinary Case Review Rounds - the CM leads weekly interdisciplinary case review rounds. The Medical Director participates during rounds to review identified complex cases as appropriate. The Medical Director is board certified and licensed in an appropriate discipline.

Each team includes, but is not limited to:

- Care Manager
- Pharmacist
- Member Connections Representatives (as needed)
- Utilization review (UM) nurses (as needed)
- Behavioral health Case Manager/ Mental health specialist
- PCP and Specialty providers

Member Engagement in the ICP Development - The ICT facilitates the participation of the member and the member's caregiver or other members of their circle of support in the development of the ICP. The member may participate in person, via telephone or through written information provided by the member/caregiver, depending on the status and/or the member's preference. Health Net may attempt to engage members during home assessments, during concurrent review and discharge planning, via telephonic contacts, and through follow up outreach letters targeting specific members and more generically through the use of a member newsletter. Our goal is to ensure the member/caregiver is able to actively participate in the development of an ICP that increases self-management, improves mobility and functional status, addresses limitations and barriers, establishes reasonable goals and creates an improved satisfaction with health status and healthcare services that result in improved quality of life. In compliance with CMS regulations, Health Net may offer member incentives to increase the member's participation in self-management.

Additional Sources of Information - Information from the primary care provider, specialists, non-professional caregivers, health records, specialist records, pharmacy data and predictive modeling aids in the full development of the ICP. The member's involvement is critical as this allows the member to be engaged in their own care and service management.

Documentation of the ICP - The CM assigned to the member is responsible for the facilitation of communication among the team and documentation of the ICP in TruCare.

ICT Role in Transitions of Care - In our efforts to maintain an ongoing partnership and to improve a member's status/condition, we have staff (i.e., Utilization Management Nurses) available telephonically for all facilities, to promote transition of care. Our goals and objectives are below:

- Early identification of members not engaged in care/service management services
- Increase identification, coordination and member awareness of discharge planning needs

- Ongoing partnership/relationship with area providers

To achieve our objectives, we may also conduct onsite health risk assessments of members and provide education regarding health options, community resources, member diagnosis/condition, and plan benefits (transportation, etc.). The CMs and the onsite staff also serve as liaisons between the facilities, PCP and the ICT. CMs assist members that were a "no show" for their scheduled follow-up appointments with rescheduling. All staff document interactions in TruCare.

Health Net's Member Handbook includes a clear description of the Care Management program.

MOC 2.D.2 How roles and responsibilities of the ICT members including members contribute to effective ICT process

Roles and Responsibilities of ICT Members - Each member of the ICT, including the member, caregivers, PCP and CM contribute to the development and implementation of an effective interdisciplinary care process by offering personal, professional and cultural knowledge and perspectives.

- Clinical Staff, including physicians, registered nurses, pharmacists, nutritional and rehabilitation specialists provide input on evidence based clinical guidelines and standards of care, specific disease states and medical conditions and available therapies.
- Social Workers contribute knowledge of the bio-psychosocial and financial impacts of chronic illness and disability as well as the social supports available to our members.
- Behavioral Health Case Managers lend expertise on integrating physical and behavioral care and services and linking members to the appropriate behavioral health providers.
- Primary Care Providers share the member's medical history, including both successful and unsuccessful treatments, the member's level of health literacy and understanding of their disease, their ability to self-manage and any issues of non-adherence to prescribed treatment. Our primary care providers are trained on conducting assessments, including the types of information that should be forwarded to the ICT for inclusion in the care planning.
- Members and their caregivers are able to interpret the member's personal experience for the team, including cultural context, health care and functional goals, perceived needs, barriers and preferences, and choice of least restrictive setting, allowing the team to customize a care and service plan of activities and interventions to meet the needs of the individual member.

Leveraging Information to Improve Member Outcomes – Health Net's CMs make use of all available data, including historical and ongoing claims data, in home assessments, pharmacy

data, utilization data, information obtained from members, caregivers, providers and formal and informal supports, to achieve a better overall understanding of the health status (physical and mental) and functional status of D-SNP members. In-home assessments often identify acute as well as chronic issues of concern. The CM ensures that acute issues are quickly brought to the attention of the member's PCP and the chronic issues of concern are brought into the ICT process and addressed in the member's ICP.

MOC 2.D.3 How ICT members contribute to improving the health status of SNP members

Member-Centric Team Approach - The composition of the ICT is member-centric and is designed to improve the health status of dual D-SNP members by offering an integrated, person centered approach to care planning and service coordination. Team members are selected based on the individual needs and preferences of the member and their ability to offer knowledge and expertise in developing an ICP that best meets the unique needs of an individual member. The ICT is responsible for the following:

- Developing and implementing individualized care plan with the member and/or caregiver's participation
- Conducting care coordination meetings on regular basis, according to the member's condition and needs; these meetings may be held face-to-face, via conference call or web-based interface
- Conducting regular case review meetings
- Detecting possible transitions in care or change in health status after a request for prior authorization is received from the member's PCP or facility
- Distributing reports to team members
- Maintaining records of team meetings
- Documenting meetings using the "Interdisciplinary Care Team" note type in TruCare

MOC 2.D.4 How the SNP's communication plan to exchange member information occurs regularly within ICT including ongoing information exchange

It is the responsibility of the CM to facilitate communication among the member/caregiver and applicable team members and to ensure documentation of ongoing information exchange. All Health Net staff involved in the member's care has access to the TruCare record and document all interactions with the member, including authorizations and care plans.

ICT Communication - Case review rounds are conducted weekly, with individual members discussed as frequently as necessary, based upon their complexity and level of need. During the meetings, the team discusses the progress of the member and provide recommendations for changes to the ICP. The Medical Director may reach out to the member's physicians to obtain clinical information on an as needed basis. The ICP is available on the

member/caregiver and Provider portals, along with care gap alerts. The Provider portal also includes a Member Health Record.

Communicating Health Information to Members and Providers - In addition to developing, implementing, and communicating the ICP, Health Net develops educational newsletters intended for both the members and contracted providers that address general health information, and introduce standards of care and services in addition to reminders for ongoing care such as preventive health services or smoking cessation.

Resolving Communication Barriers - To overcome communication barriers, and support member's engagement in care and service planning, the following strategies enhance communication with members who have hearing impairment, language barriers and/or cognitive deficiencies:

- Hearing impaired: Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
  - Speech reading (lip reading)
  - Written and visual aids
  - Visual language systems (telecommunications device for the deaf TDD)
  - Interpreters

- Language barrier:
  - Health Net utilizes translation services when no staff is available to provide translation services.
  - Members may request to have printed materials translated into another language free of charge

- Cognitive deficiencies: Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
  - Repeat information
  - Write important elements; use pictures
  - Choose best time of day to communicate
  - Keep the environment calm
  - Keep the environment quiet
  - Keep the communication simple and/or going slowly

Documenting and Addressing Member Dissatisfaction - Any member complaint or grievance identified by the ICT in their interaction with the member, their caregiver, or provider is carefully recorded and forwarded immediately to the Grievance and Appeals department for resolution and tracking.

Ongoing Communication Strategies - The success of the ICT in developing, maintaining, and updating a person centered ICP depends on strong communication. To that end, Health Net

develops several avenues for communication. The ICT (including the member/caregiver) is kept informed through conference calls, email communications, mailings and reports. The ICP is available to ICT staff in TruCare. To ensure complete and consistent documentation Health Net documents all ICT reviews and activities in TruCare.

MOC 2.E CARE TRANSITION PROTOCOLS

MOC 2.E.1 How organization uses care transition protocols to maintain continuity of care for SNP members.

Health Net uses comprehensive, member-centric discharge planning policies and procedures to ensure seamless, safe transitions and to reduce the risk of readmissions. CMs conduct discharge planning and post-discharge follow-up using policies, procedures and processes described in the SNP Transition of Care/Post Hospital Discharge Call work process.

The Transition of Care Work Process coordinates care for members moving from one care setting to another to ensure continued quality of care, reduce any potential risk to member safety, and facilitate a controlled plan so that the member receives care in the least restrictive care setting. Transitional care settings include the member's home, active home health care, acute care facilities, nursing facilities (skilled and custodial), and rehabilitation facilities. Transitions from one care setting to another involve both planned and unplanned transitions

Below we describe:

- Key elements of discharge planning policies and procedures
- Pre-discharge activities, including collaboration with the member/family and community resources involved at discharge and thereafter
- Follow-up activities after discharge to support a successful transition and reduce readmission risk.
- Integrated care team, to support a seamless transition process through collaborative care and discharge planning.

Discharge Planning Policies and Procedures
Health Net uses an integrated, person-centered model of health, behavioral health in discharge planning activities to ensure a person-centric, holistic perspective. We consistently review and adopt best practices related to reducing readmissions, which support efficient and effective care coordination, and contribute to improved quality outcomes.

MOC 2.E.2 Personnel responsible for coordinating the care transition process

Collaborative, Comprehensive Assessment and Planning - Effective discharge planning involves our concurrent review staff collaborating in person or via phone not just with the facility

discharge planning staff, but also the member/caregiver, the PCP, treating physical and behavioral health (BH) providers and CMs to comprehensively assess and develop interventions to address physical, behavioral, psychosocial, environmental, financial, cultural, and linguistic needs and barriers, including functional limitations that indicate a need for dual eligible members. The CM coordinates communication with the member, caregiver and/or family and between the discharging provider, the PCP and other applicable treating and providers. They also provide education related to available covered services, health options, and recommended care according to clinical practice guidelines. Cases are reviewed, as needed, with Health Net's own integrated care team, which includes nurses and BH clinicians, care managers, care coordinators, - social workers, pharmacist, UM nurses, disease management staff, and our Member Connections Representatives.

The concurrent review nurse/RN case managers ensures that the member's discharge plan includes referrals to appropriate post-discharge supports, including services such as home care, DME, transportation, prescriptions, and supplies, as well as community resources needed to support a safe discharge and reduce readmission risk. For example, the concurrent review nurse/RN case managers identify community resources such as food pantries, Meals on Wheels, and utility assistance programs, and incorporate them as applicable into the transition plan. The case manager contacts these resources prior to discharge to arrange for timely initiation of services when the member returns home.

Member/Family Engagement and Education - Timely communication of information to the member/caregiver or family and assisting the member to understand their condition and needs are important tools in reducing readmission risk. Our concurrent review nurse/case manager attempts to contact the member/caregiver or family in person or via phone while they are inpatient to discuss diagnoses, test and procedures, pending tests, medication lists, rationale for medication changes, contact information for the discharging physician, and all instructions and recommended follow-up care on the discharge plan. The concurrent review nurse/case manager also ensures that the member is knowledgeable about "red flags," which are indications that their condition is worsening or that they are experiencing a medication side effect, and how to respond, including self-management strategies and when to call their provider. They utilize the "teach back" method to verify that the member/caregiver understands by having the member/caregiver restate the discharge instructions and self-care concepts in their own words.

MOC 2.E.3 How organization transfers elements of the members ICP between health care settings when member experiences a transition

Communication of Information to the Next Care Setting - The CM ensures that all treating providers have full information about the member's care history and current needs as well as the context for planned care. The CM also ensures that they know whom to contact with questions regarding the member's care history or follow-up care. For admissions, the CM provides information to the facility regarding the member's ICP, authorized services and

providers to support assessment and discharge planning. The concurrent review nurse/case manager alerts the PCP of any transition in care setting. The concurrent review nurse or the CM collaborates with the facility treating physicians and BH providers, as appropriate, to facilitate discharge planning and follow-up as needed. The concurrent review nurse or the CM coordinates and facilitates provider communication, and ensures that the PCP and all treating providers, including formal and informal community supports, as appropriate, are involved in the planning for the anticipated transition. The discharge plan is incorporated by the CM into the ICP.

MOC 2.E.4 How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.

All SNP members are provided their Individual Care Plan that can be shared with providers in other care plan settings and/or health specialists outside of their primary care network. Any member may request that he or she be allowed to inspect and/or obtain a copy of any of their Protected Health Information that is maintained by or for Health Net in a designated record set. The member, or any other person who is qualified to act as the member's personal representative under state or federal law, may make the request.

Arranging Timely and Appropriate Primary Care and Specialist Follow-up Prior to Member Discharge - Prompt follow-up with the PCP or other outpatient specialty provider after discharge is critical in preventing readmission. Our concurrent review nurse/case manager takes steps prior to discharge to ensure that the member receives timely and appropriate follow-up care. These steps include but are not limited to scheduling follow-up appointments and transportation, as needed; verifying anticipated start date/time for community based care and services and working with the CM and the member/family to fill any gaps between discharge and initiation of community services.

MOC 2.E.5 How members are educated about their health status to foster appropriate self-management activities.

Post-Discharge Outreach, Education, and Assessment - The assigned CM conducts post-discharge follow-up with the member within 72 hours of notification of discharge to verify that they have been able to get prescriptions, equipment, and supplies. They review with the member/caregiver the discharge plan to ensure they understand the importance of accessing recommended follow-up care, address barriers to accessing follow-up care, and review red flags and the process for contacting the PCP or other providers when complications arise. The CM educates the member/caregiver about how to use our after-hours nurse advice line.

The goal of post-discharge follow up is to assist members in closing identified healthcare gaps and barriers during transitions from an inpatient hospital to home. We focus on care coordination, health education, medication adherence, and follow-up appointments in order to promote healthy behaviors and reduce the risk of readmission, and ensure that the member can remain in a least restrictive setting of their choice.

Medication Reconciliation - Medication reconciliation is a critical element of care transitions and preventing readmission due to medication error or adverse event when a member has poly-pharmacy, low health literacy, or communication barriers. The CM ensures that the member is able to safely use medications in accordance with their discharge plan and confirms that the member has picked up his/her medications. Medication reconciliation may be done telephonically by a RN case manager, pharmacist, or by a home health agency RN. This includes checking the accuracy of medication lists; identifying changes in medication regimen, duplication of therapy and/or potential interactions with medications in the home; and assuring that the member/caregivers understands changes and side effects that should be reported to his/her PCP. It also includes communicating the discharge medication regimen to the PCP.

Pre-Discharge Activities - When Health Net identifies that a member has been admitted or has a scheduled admission, the concurrent review nurse/case manager begins working with the facility staff, providers, and the member to coordinate care, ensures a safe discharge, and reduces readmission risk. Discharge planning of an inpatient admission starts as early in the admission as possible. The concurrent review nurse/case manager conducts onsite or telephonic reviews and outreaches to facility staff to obtain clinical information, assesses members' conditions, needs, and potential discharge. The concurrent review nurse and/or the CM participates in facility care conferences, as needed, to identify barriers, discuss the member's progress, and help develop and coordinate the discharge plan. He/she also notifies and shares information with the PCP and other treating providers, such as BH providers to ensure an integrated approach to services and discharge planning, and ensures necessary authorizations are in place for ordered services such as home care services. Nurses conducting telephonic concurrent review and discharge planning ensures that transition plans are person-centered, meet the members clinical needs, consider the members' goals and preferences, and supports them in achieving desired health outcomes, including being able to safely reside in the least restrictive setting of their choice, while preventing readmission.

The CMs use information from the facility, treating providers, and the members to identify members' at risk for readmission. This includes but is not limited to members with complex medical and social needs, co-existing medical and BH conditions, and members with a history of non-compliance or poor community supports. CM supports concurrent review nurses as follows:

- Identify and attempt to resolve barriers to care
- Coordinate initiation of services such as home health and DME
- Encourage medication adherence and follow-up care
- Assist with scheduling follow-up appointments
- Assist with scheduling transportation to scheduled appointments
- Complete referrals to appropriate community agencies
- Discuss "red flags", and when to contact the PCP, the use of the Emergency Room and Urgent Care Centers and what is considered a true emergency

For members with complex needs, Health Net conducts multi- disciplinary rounds to support the concurrent review nurse/case manager. This case review process brings a holistic look at members' needs, risk factors, preferences, goals, and barriers to achieving desired goals, and develops recommendations for the discharge plan and post-discharge services to successfully support the member's transition out of the hospital and prevent readmission.

Collaborating with the Member/Family - During admission, our concurrent review nurse, or CM attempts to talk in-person or via phone with at-risk members, their provider(s), and family/supports as appropriate, to the following:

- Assess health status, care plan changes, any needs such as unmet education or psychosocial needs, reasons for unplanned admissions and ED visits, and potential risks and barriers in their environment which potentially will, or in the case of readmission, have interfered, with a successful recovery. Assessment also includes the evaluation of the member's functional status, health literacy, self-management skills, social and community supports and culture and language needs
- Provide education about the member's condition, red flags, and other topics (as described above)
- Conduct medication reconciliation
- Involve the member in discharge/service planning
- Assist the member as needed with choosing providers of post-discharge services
- Educate the member and their caregivers about available Health Net support to help connect caregivers to support groups and other community resources

Collaborating with Community Resources to be Involved at Discharge and Thereafter - The goal of Health Net's Transition of Care is to provide whole health management across the continuum of care as well as to identify and address social determinants of health, which impact the member's health outcomes and ability to remain in the least restrictive setting of their choice. To accomplish this, the concurrent review nurse/CM go beyond a purely clinical approach to developing discharge plans by identifying and addressing barriers related to physical, behavioral, socioeconomic, functional status, and other needs such as food, housing, or other assistance.

MOC 2.E.6 How the beneficiaries and/or caregivers are informed about the point of contact throughout the transition process.

Pre-Discharge Education - The CM attempts to discuss the final discharge plan and instructions with the member (and applicable family/informal supports). This includes assisting the member with developing actions to prevent avoidable ER and inpatient utilization, if the member's condition and cognitive status permits such interaction at that time.

General Discharge/Post-Discharge Procedures

The concurrent review nurse or the CM handling discharge planning collaborates with facility staff to ensure that these appointments are scheduled before the member is discharged from the facility. The CM contacts the member via telephone within 72 hours of discharge.

During the follow-up phone call to members, the CM does the following:

- Review and reinforce discharge instructions, and provide additional education to ensure the member understands his/her condition, needed follow-up, and the importance of adherence and timely follow-up. This activity is critical because discharge instructions typically provide limited information, and the member's health literacy level may limit their understanding. Additionally, the member may not retain any education received in the hospital due to such issues as stress, pain, or medications.
- Complete a medication reconciliation of newly prescribed medications and all others the member may be taking to identify any potential issues, such as duplication or contraindications; identify any barriers to the member's compliance in taking the medications, provide education on why the medication is needed and the appropriate way to take the medication.
- Ensure a follow-up is scheduled, and assist as needed with scheduling follow-up appointments, arrange transportation if needed, and address any other barriers to timely access.
- Confirm initiation of home care and the delivery of medical equipment/supplies.
- Assist the member in determining if they understand what symptoms they should look for, what to do when they have those symptoms, and how to contact their PCP in order to reduce avoidable ED visits and readmissions. The CM educates the member on how to contact the Case Manager or, after hours, how to use our 24/7 Nurse Advice line if they have any questions.

Ensuring Members Are Connected With Community Resources - During the post-discharge contact described above, the CM confirms whether the member has accessed the community resources in the transition plan. If not, the CM follows-up directly with the community resources to discuss the member's needs and ensure services are available and are provided timely.

For members whose hospitalization resulted from a BH issue, the CM collaborates with the BH Coordinator for continued behavioral health needs.

Post-Discharge Monitoring - The CM follows the member's progress throughout the post-discharge transition period. Typically, follow-up for members extends 30 days from discharge, but may extend beyond 30 days depending on the member's needs and condition. Any member identified as needing more intensive education and support following discharge may receive a referral for a home health provider to ensure the member understands the importance of, and is accessing follow-up care appropriately, and adhering to medication regimens. Once the

member is stable, the CM assesses the member for ongoing care management needs and referral for disease management education and health coaching.

Integrated Care Management for Ongoing Needs - Members who continue to need monitoring and support is supported by Health Net's own integrated care team. This team includes a social worker, BH clinician, pharmacist, health coach and non-clinical supports. Furthermore, the CM, which constitutes the "one point of contact" for the member and the providers, communicate the newly updated ICP to the ICT. The ICT collectively reviews and provides interdisciplinary input on the member's needs and care. Team members, regardless of background, receive training on basic information about detecting and appropriately referring for potential medical and behavioral needs. Clinical staff receives more in-depth training on the causes, evidence-based treatment, components of care, potential barriers to care, and expected outcomes of both medical and BH conditions, particularly those that often occur co-morbidly. This approach helps to avoid unnecessary readmissions by ensuring an integrated approach to each member's ongoing needs and care.

MOC 3: PROVIDER NETWORK

MOC 3.A SPECIALIZED EXPERTISE

MOC 3.A.1 How Providers with specialized expertise correspond to the target population identified in MOC 1.

Health Net maintains a comprehensive network of Primary Care Providers, facilities, specialists and ancillary services to meet the needs of SNP members with chronic disease such as diabetes, cardiac, respiratory, musculoskeletal and neurological disease and behavioral health disorders. Contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, outpatient pharmacies, and hospices allow SNP members to obtain the services they need at a convenient location. The Health Net website also has a user friendly search function for members to locate providers and specialists in their area. Please see Health Net HSD tables for complete details on primary and specialist providers and facilities.

The specialized expertise of the provider network meets the unique healthcare needs of SNP members as described in MOC 1. Following is a partial listing of how the providers in the network can address the healthcare needs of Jade SNP members:

- Primary Care Providers such as family care practitioners and internists provide chronic disease management such as diabetic and cardiovascular care and coordination with the ICT, and referrals to specialists and ancillary services such as home care and restorative therapists

- Behavioral health practitioners meet the counseling and psychoactive medication needs of members with mental health disorders such as depression, substance abuse, schizophrenia and paranoid disorders

- Cardiologists provide cardiac medication and disease management as needed for members with CHF, hypertension, cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorders

- Endocrinologists provide medication and disease management expertise as needed for diabetics, hypothyroidism, hyperthyroidism and other endocrine disorders

- Neurologists are available as needed to treat members with cerebrovascular disease, stroke, Alzheimer's and dementias, peripheral neuropathies and other nerve tissue disorders

- Pulmonologists provide treatment for members with respiratory conditions such as asthma, COPD and other airway disorders

- Gastroenterologists provide treatment for conditions such as irritable bowel disease, Chrohn's disease, digestive disorders and colonoscopy and stoma care.

- Nephrologists provide treatment members with disorders of the kidneys such as chronic renal failure, electrolyte disorders, kidney stones and infections

- Dermatologists provide medication and treatment for members with skin cancers, wound care, skin infections and other skin disorders

MOC 3.A.2 How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.

Health Net operates as both a delegated and traditional model for managed health care delivery. In the delegated model, Health Net may delegate responsibility for activities associated with utilization management, credentialing and case management to select medical groups. Groups with the infrastructure to provide the SNP Model of Care can also be contracted and responsible for the team-based Model of Care requirements. Members that are not part of a group delegated for the SNP Model of Care receive the team-based care through Health Net. As part of the delegation oversight process, HN conducts a structured pre-delegation evaluation to include analysis of program documents, audit of related files and an on-site review of the SNP delegated group's operations. The evaluation results are compiled and a written summary of the findings and recommendations are presented to the Delegation Oversight Committee. This type of audit is also performed annually, at a minimum, to determine the continuation of the delegated relationship. Delegated groups that do not meet the SNP program requirements as determined by the delegation oversight committee are de-delegated.

The Health Net Credentialing Department obtains and reviews information on credentialing or re-credentialing applications and verifies the information is in accordance with Health Net's primary source verification practices. Health Net requires groups to which credentialing has been delegated to obtain primary source information in accordance with Health Net standards of participation, state and federal regulatory requirements and accrediting entity standards.

Prior to providing health care services to Health Net members, all practitioners seeking admission to the Health Net network undergo a comprehensive review and verification of professional credentials, qualifications and other background checks. This review is conducted in accordance with Health Net standards for participation requirements, state and federal regulatory requirements and accrediting entity standards. All initial applicants are notified of the Credentialing Committee's decision within 90 days of Health Net's receipt of a completed application.

Following initial approval into the network by the Credentialing Committee, practitioners are re-credentialed within 36 months. Practitioner re-credentialing includes reviewing Health Net captured performance data that provide an assessment of indicators representing professional competence and conduct. Practitioners identified in the initial or re-credentialing processes with adverse actions will be investigated in accordance with *Policy/Procedure #CR140: Adverse Action.* In addition, Health Net conducts ongoing monitoring of sanctions and complaints in accordance with the guidelines established by the credentialing policy.

The credentialing process is also administered by Health Net approved delegated entities that qualify and agree to credential practitioners in accordance with Health Net's credentialing standards, state and federal regulatory requirements and accrediting entity standards. Oversight of delegated credentialing and re-credentialing activities is administered under the direction of the Health Net Delegation Oversight Committee and in accordance with process described in *Policy/Procedure #CR180: IPA/Medical Group/Entity Evaluation & Delegation Determination – Credentialing.*

Health Net retains the right to approve, deny, suspend or terminate any and all practitioners participating in the Health Net network. All records, electronic or hard-copy, are maintained in accordance with Health Net corporate retention policies and procedures.

Health Net Incorporated (HNI), Behavioral Health Division, Managed Health Network (MHN) is responsible for the credentialing/re-credentialing of the Health Net behavioral health care network. MHN credentials and re-credentials practitioners in accordance with state and federal regulatory requirements and accrediting entity standards prior to providing health care services to Health Net members. Health Net credentials those behavioral health care practitioners not credentialed by MHN. Please see the Health Net Credentialing and Re-credentialing Policy for complete information:

The practitioner must complete all items on a Health Net approved application and submit all requested supporting documentation. The verification time limit for a Health Net approved application is 180 days. The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely, including but not limited to:

- *Present illegal drug use*
- *History of loss of license or certification*
- *History of criminal/felony convictions*
- *History of loss or limitation of privileges or disciplinary actions with any health care entity*
- *Any inability to perform all essential functions of the contracted specialty(ies), with or without accommodation, according to criteria of professional performance*
- *Current malpractice insurance coverage*

The practitioner will attest to the completeness and truthfulness of all elements of the application. Information submitted on the application by the practitioner must be supported by verifiable sources.

The practitioner must provide continuous work history for the previous five years. The verification time limit is 180 days. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing. All verbal communication will be documented in the file. Any gap(s) in work history that exceeds one year must be clarified in writing.

The practitioner must possess a current, valid license or certificate issued by the state in which the practitioner is applying to practice. The verification time limit is 180 days. Licenses that are limited, suspended or restricted will be subject to investigation, administrative termination or denial, as outlined in *Policy/Procedure #CR140: Adverse Action, Attachment A: "Adverse Action Classification Guidelines."*

The practitioner must possess adequate and appropriate education and training as stated in *Attachment C: "Board Certification/Education Table."* The board certification verification time limit is 180 days; verification of medical school/residency completion is valid indefinitely.

The practitioner for whom hospital care is an essential component of their practice must possess admitting privileges with at least one Health Net participating hospital or freestanding surgery center. A documented coverage arrangement with a health net credentialed practitioner of a like specialty is a requirement in lieu of admitting privileges. Hospital privileges that have been impacted for quality of care reasons will be acted upon as outlined in *Policy/Procedure #CR140: Adverse Action, Attachment A, "Adverse Action Classification Guidelines."*

The practitioner must possess a valid, current drug enforcement administration (DEA) and/or controlled dangerous substances (CDS) certificate, if applicable. The document must be current at the time of the credentialing committee decision. Health Net verifies a DEA or CDS certificate in each state in which the practitioner is contracted to provide care to its members. If a practitioner does not have a DEA or CDS certificate, Health Net obtains an explanation that includes arrangements for the practitioner's patients who need prescriptions requiring DEA certification.

The practitioner will possess malpractice insurance coverage that meets Health Net standards. This information must be documented on the application or submitted as a face sheet. The

document must be current at the time of credentialing committee decision. Exceptions may be granted for post-dated insurance coverage as indicated in the "policy statement" section of this policy. The practitioner will assist Health Net in investigating professional liability claims history for the previous five years.

The practitioner must be absent from the Medicare/Medicaid cumulative sanction report if treating members under the Medicare or a Medicaid line of business. The verification time limit is 180 days. Practitioners with identified sanctions will be investigated according to the leveling guidelines established by *Policy/Procedure #CR-140: Adverse Action, Attachment A: "Adverse Action Classification Guidelines.*" The practitioner must be absent from the Medicare opt-out report if treating members under the Medicare line of business. The verification time limit is 180 days. The practitioner must be absent from the federal employee health benefits program debarment report if treating federal members. The verification time limit is 180 days.

The Health Net contracting department is responsible to determine that the facilities it contracts with are actively licensed and/or accredited. Health Net also encourages transparency by providing Health Net's Hospital Comparison Report on the member website. The Hospital Comparison Report has easy to understand details about hospital treatment outcomes, the number of patients treated for a particular illness or procedure, and the average number of days needed to treat that illness or procedure. Health Net also encourages the hospitals in its network to participate in the Leapfrog Hospital Quality and Safety Survey, a national rating system that gives consumers reliable information about a hospital's quality and safety based on computer physician order entry, intensive care physician staffing and experience with high-risk and complex medical procedures.

MOC 3.A.3 How the SNP documents, updates, and maintains accurate provider information.

The Credentialing Department has established a re-credentialing cycle through which each non-delegated practitioner's re-credentialing materials are processed at least every 36 months. The Credentialing Department forwards a re-credentialing package/notification to the practitioner and/or IPA/medical group eight (8) months in advance of the scheduled reappointment date. Practitioners with current Council for Affordable Quality Healthcare (CAQH) on-line credentialing/re-credentialing applications do not receive re-credentialing notices.

By completing and signing the re-credentialing application, the practitioner:
a.) affirms the completeness and truthfulness of representations made in the application;
b.) indicates a willingness to provide additional information for the credentials process;
c.) authorizes Health Net to obtain information regarding the applicant's qualifications, competence or other information relevant to the credentialing review, and
d.) releases Health Net and its independent contractors, agents and employees from any liability connected with the credentialing review.

The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely. The Credentialing Department completes a review of the practitioner's re-credentialing file and conducts primary source verification as outlined in the Primary Source Verification Tables specified for re-credentialing. Practitioner performance data include, but are not limited to, member complaints and quality improvement activities. These data are incorporated into each re-credentialing file to be reviewed by the Credentialing Committee for a decision.

A roster of practitioners who are administratively noncompliant with Health Net re-credentialing criteria is presented to the Credentialing Committee for consideration and decision-making. A list of terminated practitioners is forwarded to Provider Network Management and/or Provider Data Management staff for deletion from the Health Net network where all provider information is housed and updated.

MOC 3.A.4 How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services.

Health Net's Care Managers successfully engage our provider network to participate in and work with the ICT and to contribute to the ICP through the following steps:

- Sharing the identification of health care and service needs and risks
    - CM staff conduct the Medicare CM Assessment/HRA by phone, in the member's home, residence site or facility
    - By completing such an assessment, the CM will determine the specialty providers, allied health or support services (durable medical equipment, home health services, meals and other home and community-based services) needs of the member
    - CMs share results and analysis of the Medicare CM Assessment/HRA with the member's PCP and with all other healthcare providers and other staff, "the ICT", identified by the CM as necessary to handle the member's identified needs and preferences
    - CM performs outreach to PCP to share issues and concerns and to obtain feedback and resolution of issues
- Developing the member's individualized care plan with the member and/or caregiver, PCP and other external ICT members based on the member's health care, social and functional needs
    - Care Managers develop an initial ICP that is adjust vased on the subsequent ICT discussions. CMs lead the initial ICT meeting, as well as all subsequent meetings, where the member's specific needs are addressed; proposed course(s) of action are presented to the member/caregiver by the members of the ICT and based on the

member's desires. The ICP is developed with specific goals and steps to follow.

- Providing the PCP and other members of the ICT with one point of contact at Health Net to coordinate care and ensure service delivery
    - Members of the ICT receive as single "one point of contact": the member's CM
    - CMs help educate the provider network in general and the ICT, in particular, on services and benefits available to the member
    - CMs serve as the point of contact to the members of the ICT to facilitate and authorize all needed benefits and services, provide appropriate information about the UM rules and monitor timely delivery of services
- Notifying the PCP and other members of the ICT of care transition and/or significant clinical, behavioral, functional or social status change that their assigned health plan member may encounter to ensure smooth transition of care with the proper adjustment of services
    - CMs, for example, provide members of the ICT documentation related to a member's transition from home care to a nursing facility, a discharge from the hospital to a nursing facility, a visit to the emergency room
    - CMs are responsible for communicating to the ICT, the participants' change in health status, the need for modification to the member's ICP,
    - CMs request, from the ICT, information related to preventative health screenings being completed or remind them of gaps in care that need to be closed

MOC 3.B.USE OF CLINICAL PRACTICE GUIDELINES AND CARE TRANSITION PROTOCOLS

MOC 3.B.1 Explaining the processes for monitoring how network providers utilize appropriate Clinical Practice guidelines and nationally recognized protocols appropriate to each SNP's target population

Clinical practice guidelines (CPGs) are developed and/or adopted to reduce variation in practice and improve the health status of members. Health Net adopts nationally recognized, evidence-based clinical practice guidelines for medical and behavioral health conditions through the national Medical Advisory Council (MAC). Health Net Medical Directors are involved in the review and update process for clinical practice guidelines through MAC and meet at least 10 times per year. Specialty input on guidelines is obtained when indicated. Guidelines are evaluated for consistency with Health Net's benefits, utilization management criteria, and member education materials. MAC evaluates new technologies (medical and behavioral health), and devices for safety and effectiveness. The CPGs are reviewed at least every two years or more frequently when there is new scientific evidence or new national standards are published.

Approved national medical policies and clinical practice guidelines are published and made available to the network providers through the provider portal of the Health Net web site and through provider updates. Physicians are informed about current preventive care guidelines

through regularly updated provider operations manual and as indicated through provider updates. The preventive guidelines Health Net endorses are published by, but not limited to, USPSTF, ACOG, AAP, CDC, AAFP and ACS. Provider groups are required to participate in the collection of HEDIS® data to monitor and ensure clinical care is consistent with evidence based clinical guidelines. In addition, the processes for appeals, grievance and potential quality issues identify deviations from accepted clinical practice and action is taken as indicated.

Physician compliance with CPG is monitored through the HEDIS® outcomes for SNP members. Health Net has a process to inform provider groups in a timely manner of their performance on select HEDIS® and Part D pharmacy measures so they can improve practices. Providers are also educated about the SNP program outcomes for HEDIS® and preventive measures during Provider webinars and through newsletters and online news and encouraged to provide input on barriers and how to improve rates.

MOC 3.B.2 Identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries

Health Net recognizes that nationally developed procedures and guidelines are often designed for standard medical cases, but may not apply to members with complex needs. Such cases include challenges related to medication, prescriptions, facility placement, surgical intervention and other medical treatments.

In a broad context, all standard criteria/guidelines (e.g., NCD, LCD, InterQual, Clinical Practice Guidelines) and Health Net developed clinical protocols/standards are reviewed at least once a year and adopted in consultation with network providers. Adopted or revised guidelines are then distributed via online postings, faxes, portals and/or newsletters to network providers. Network providers are also able to request updates via mail. General revision challenges, such as changes in member population, new scientific evidence, or evolving industry standards, dictate when updates are needed on an ad-hoc basis. In addition, revisions are also considered and/or implemented annually. For example, changes to cancer screening protocols necessitating guideline revisions.

MOC 3.B.3 Provide details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICP and acted upon by the ICP

Process to Modify CPG and/or Clinical Protocols - More specifically, when a member with complex needs fails to meet applicable medical criteria/guidelines during the UM process for prior-authorization, the case is referred to Health Net's Medical Director. The Medical Director reviews all pertinent clinical information, including applicable peer review literature. He/she considers relative information during the review, such as member's age, comorbidities, complications, current treatment, psychosocial factors and home environment. Once the Medical Director concludes a clinical decision, such decision is communicated to the ICT, the

member's PCP and the member/caregiver as needed, to ensure medically appropriate care or service is provided and within the allowed benefits. The Medical Director makes him/herself available to discuss his/her decision with the ICT, at the team's request and convenience. Lastly, the ICP is adjusted according to the final decision and the new adjusted ICP is distributed to the ICT members, and verbally shared with the member/caregiver. The Care Managers (CM) monitor the timely delivery of the requested services to the member.

When network providers identify challenges/don't agree based on their own experience with clinical protocols, they are able to do the following:

- Request a change in Health Net guidelines by submitting evidence to be considered on an individual prior authorization request
- Request a revision of the overall guideline
- Request a peer-to-peer review
- Submit an appeal form for any adverse determination/denials

In all instances, providers are encouraged to submit additional clinical evidence for consideration or information about a particular case.

Overall, these methods help Health Net revise and address challenges/exceptions to clinical practice guidelines for the unique health needs of members.

MOC 3.B.4 Describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.

Health Net's Care Coordination provides crucial connections when members transition from one care setting to another. This activity is critical to providing a safe and smooth transition. Health Net's CMs mediate member transitions to/from the hospital, home, nursing facility or to a totally new care setting and involve the member/caregiver as well as all care providers responsible for the services and supports in the new setting.

Transition protocols include the following:

- Addressing the member's individual needs, strengths, preferences, and goals
- Educating the member/caregiver on his/her condition
- Supporting medication adherence and reconciliation
- Ensuring timely initiation of post-discharge services and care such as post-discharge office visits and other services, home health care services, etc.
- Linking member to available community supports

These protocols are implemented and managed by Health Net clinical resources.

CCRs ensure that the member's PCP receives notification within 24 hours of care transition. CMs request the documentation related to the transition in care, e.g., completed discharge

summary, history and physical, specialty consultation reports, and any pertinent information such as main issues, post-discharge required services. CMs communicate with the PCP, update the ICP and provide updates to the ICT members and the member/caregiver. Finally, they follow-up on all outlined tasks with the member, providers and ancillary services to ensure that all activities outlined in the transition plan and in the updated ICP are completed in a timely fashion. This process ensures a seamless transition for the member and reduces readmission risk.

In the event that a provider is non-compliant or resistant to working with the CM, the network team mediates the conflict by providing outreach and facilitating compliance discussions. They also deliver training to providers if there is an educational gap related to the care transition protocol.

3.C MOC TRAINING FOR THE PROVIDER NETWORK

MOC 3.C.1 Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.

Providers responsible for the administration or delivery of the SNP Model of Care are provided initial and annual training. Training is offered through multiple learning environments to meet individual learning needs. SNP members would not receive care on a routine basis from an out of network provider because the product is HMO based - they would be set up with an in-network provider for ongoing care. Methodology may be lecture format, interactive (web-based, video conference) or self-study (printed materials, electronic media). Comprehensive MOC training includes topics of: Goals of the MOC, SNP Population, Additional benefits, Case Management, HRA, ICP, ICT Care transitions, Coordination of Medicare and Medicaid and the Quality Improvement Program. Representative slides from the 42 page deck are provided here:

Health Net

Learning Objectives

Program participants will be able to:

- List the three overall goals of the SNP Model of Care
- Describe the three qualifying medical conditions for patients in the Health Net Jade C-SNPs
- Name two actions providers can take to assist patients in the Dual Eligible Amber D-SNPs to access care
- Understand the important components of the care plan and team based care to improve care coordination for SNP patients
- Name two principles important to improve transition care management
- Identify three outcomes being measured to evaluate the Model of Care

2

Health Net

Goals of Special Needs Plans

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Assuring appropriate utilization of services

Improve Outcomes

- Improving patient health outcomes

4

Health Net

Health Net SNPs

Health Net has two types of SNPs:

- D-SNPs for patients that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- C-SNPs for patients with chronic and disabling disorders known as the Jade SNPs - one or more of the following chronic diseases is required depending on the specific plan:

1. Diabetes
2. Chronic Heart Failure
3. Cardiovascular Disorders:
   - Cardiac Arrhythmias
   - Coronary Artery Disease
   - Peripheral Vascular Disease
   - Chronic Venous Thromboembolic Disorder

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Health Net

Vulnerable SNP Sub-Populations

Populations at greatest risk are identified in order to direct resources towards the patients with increased need for case management services.

- Complex and multiple chronic conditions – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- Disabled- patients who are unable to perform key functional activities independently such as ambulation, eating or toileting, such as members who have suffered an amputation and blindness due to their diabetes
- Frail – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty
- Dementia – patients at risk due to moderate/severe memory loss or forgetfulness
- End-of Life- patients with terminal diagnosis such as end-stage cancers, heart or lung disease

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Health Net

Benefits to Meet Specialized Needs

- **Decision Power Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation** – these benefits vary by region and type of SNP

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Health Net

Communication Systems

Multiple communication systems are necessary to implement the SNP care coordination requirements:

- An **Electronic Medical Management System** for documentation of case management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with enrollment, eligibility and coordination of benefit questions and able to meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate HRA results and new member information to SNP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online

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Health Net

Language/Communication Resources

SNP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication and have negative impact on health outcomes.

- Office interpretation services- in-person and sign-language with minimum of 3-5 days notice
- Health Literacy - training materials and in-person training available)
- Cultural Engagement – training materials and in-person training available
- Health Net translates vital documents
- 711 relay number for hearing impaired

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Health Net

Evidence Based Case Management (CM)

- All SNP patients enrolled in case management and notified of CM single point of contact by letter/follow-up phone call
- Patients may opt out of active case management but Case Manager continues to attempt an annual contact or when change in status or transition in care.
- Patients are stratified according to their risk profile and Health Risk Assessment (HRA) to focus resources on most vulnerable (frail, disabled, chronic diseases)
- Patients with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive primary case management from MHN, Health Net's Behavioral Health provider
- Contingency planning is in place to avoid disruption of services for events such as disasters

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Health Net

Health Risk Assessment (HRA)

- An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Health Net attempts to complete initial HRA telephonically within 90 days of enrollment and annually or if there is a change in the patients condition or transition of care
- Multiple attempts are made to contact the patient including mailed surveys and e-mail reminders
- The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail
- Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan

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Health Net

Individualized Care Plan (ICP)

Created for each patient by the Case Manager with input from the care team. The patient and/or caregiver is involved in development of and agrees with the care plan and goals:

- Based on the patient's assessment and identified problems
- Goals are prioritized considering patient's personal preferences and desired level of involvement in the process
- Updated when change such as new diagnosis/hospitalization or at least annually and communicated to ICT and patient
- Accessible/shared with members of the ICT including patient and provider
- Includes patient's self-management plans and goals
- Includes description of services tailored to patient's needs
- Includes barriers and progress towards goals

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Health Net

Interdisciplinary Care Team (ICT)

The Health Net, MHN or delegated Case Manager coordinates the ICT which communicates regularly to manage the patient's medical, cognitive, psychosocial and functional needs. The patient and/or caregiver is included on the ICT whenever possible:

- Required Team Members

Medical Expert
Social Services Expert
Mental/Behavioral Health Expert – when indicated

- Additional Team Members could be

Pharmacist
Health Educator
Restorative Therapist
Nutrition Specialist
Nursing/Disease Management

- Communication plan for regular exchange of information within the ICT including accommodations for members with sensory, language or cognitive barriers

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Health Net

Care Transition Protocols

Patients are at risk of adverse outcomes when there is transition between settings (in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers or home health)

- Patients experiencing an inpatient transition are identified and managed (pre-authorization, facility notification, census)
- Important elements (diagnoses, medications, treatments, providers and contacts) of the patient's care plan transferred between care settings before, during and after a transition
- Patient knowledgeable of health information to communicate care to other healthcare providers in different settings
- Patient is educated about health status and self-management skills: discharge needs, meds, follow-up care, signs of change and how to respond (discharge instructions, post-discharge calls)

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Specialized Provider Network

- Health Net maintains a comprehensive network of primary care providers and specialists such as cardiologists, neurologists and behavioral health practitioners to meet the health needs of chronically ill, frail and disabled SNP patients
- Team based case management is provided by Health Net when it is not delegated to the patient's primary care provider and medical group
- Delegated medical groups must demonstrate capability to meet the team based care requirements
- The Delegation Oversight team conducts audits to monitor that delegated medical groups meet the SNP Model of Care requirements

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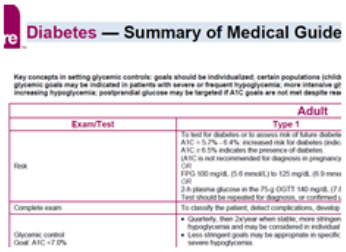
Jade C-SNPs – Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Diabetes, the program has:

- Disease Management to assist patients to manage their Diabetes
- Interactive programs for healthy activity and weight control
- Additional benefits (vary by plan) can include zero cost for Diabetic monitoring supplies, low cost Podiatrist visits
- Clinical Practice Guidelines for Diabetes and other chronic diseases located on the Provider Portal


Diabetes — Summary of Medical Guide

Adult

Exam/Test	Type 1
Risk	
Complete exam	
Glycemic control Goal: A1C <7.0%	

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D-SNPs -Coordinating Medicare and Medicaid

The goals of coordination of Medicare and Medicaid benefits for members that are dual-eligible:

- Members informed of benefits offered by both programs
- Members assisted to maintain Medicaid eligibility
- Member access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and Medicaid

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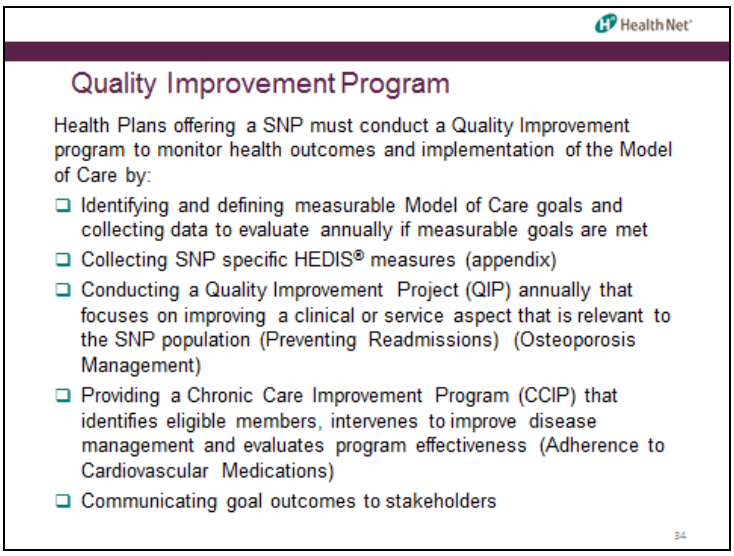
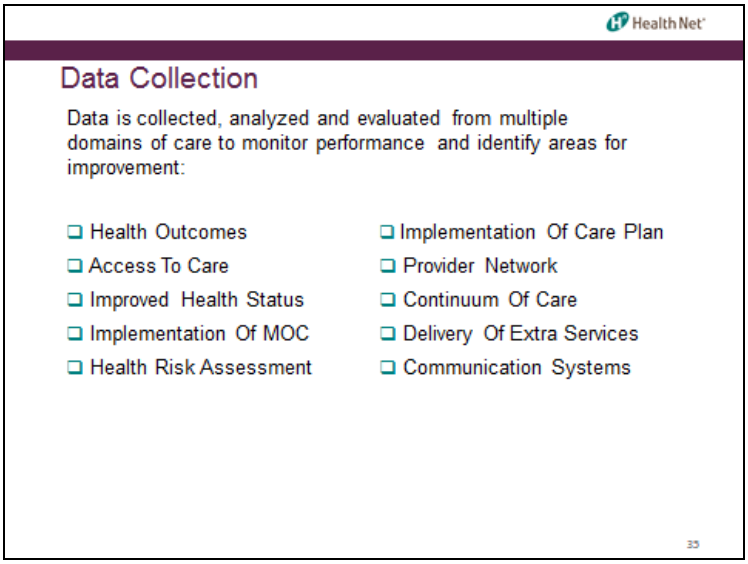




The SNP MOC training is updated annually and presented as a provider webinar. The updated training is then posted on the provider web portal and the provider manual so it is accessible to providers at any time. This training is also available to delegated groups to use with their staff. Health Net also offers additional provider webinars on topics that are relevant to the Model of Care such as chronic disease management and best practices throughout the year. These topics vary each year and new topics are selected based on provider interest and initiatives to improve outcomes.

Online, providers also have access to information and policies on the SNP program through the electronic Provider Manual. Providers are notified of changes and regulatory revisions through ongoing online news articles and faxed provider updates.

MOC 3.C.2 Documenting evidence that the organization makes available and offers training on the MOC to network providers.

Training materials including attendance records for SNP MOC provider training are documented, retained and retrievable upon request. Provider webinar training records including attendee name, company and phone number for the MOC training are provided by the webinar company, dated and maintained. As stated earlier, Health Net posts the MOC presentation on the provider web portal for medical groups to share with providers who are unable to attend providing 24 hour access to MOC training to providers.

In addition, Delegation Oversight completes annual audits of SNP delegated groups. One of the elements of this audit is confirming that there is documented evidence of SNP MOC training. As part of the annual provider compliance training, participating provider groups also complete attestation for SNP MOC training as applicable.

MOC 3.C.3 Explaining challenges associated with the completion of MOC training for network providers.

There are a number of challenges associated with completing MOC training for network and out-of-network providers that include the following:

- Providers lack time to complete MOC training due to the demands of patient care
- Providers are asked to complete MOC training from multiple managed care plans resulting in lost productivity and duplication of effort
- Providers have variable MOC knowledge. Newly participating providers may benefit from the training whereas an established network provider may be very familiar with the program and care management processes detailed in the MOC.
- Out-of-network providers have no contractual responsibility to complete MOC training

MOC 3.C.4 Taking action when the required MOC training is deficient or has not been completed.

The Delegation Oversight team conducts a pre-delegation audit and an annual audit to ensure contracted providers delegated for SNP have complied with requirements. If the delegate does not have documentation of annual MOC staff training, a corrective action plan for noncompliance is required and monitored until the issue has been resolved in a timely manner. Participating providers missing attestations are also tracked and outreach is made until the attestation is completed.

MOC4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

4.A MOC QUALITY PERFORMANCE IMPROVEMENT PLAN

MOC 4.A.1 Describe the overall quality improvement plan and how the organization delivers or provides appropriate services to SNP members based on their unique needs

At the member level, the SNP MOC provides case management for all members to meet their unique needs. A comprehensive assessment is completed to assist in the development of a person-centric Care Plan incorporating the member's individualized needs and goals. The program provides care coordination and complex case management including decision support, member advocacy, identification and recommendation of alternative plans of care and community resources to support the plan of care. Overall, the goal of Case Management is to promote the member's desire to self-direct care and help members regain optimum health or improved functional capability in the right setting and most cost effective manner. Individual goals determined with the member are measurable, within a certain timeframe and are monitored for completion to meet the member's unique needs.

At the organization level, the Quality Improvement Program evaluates that appropriate services are delivered to SNP members by looking at a comprehensive set of utilization, access, satisfaction, audit and clinical measures to measure improvement and effectiveness of the Model of Care and to identify areas for improvement. Appropriate clinical measures such as diabetic and cardiovascular measures are collected to evaluate a chronic disease SNP. Controlling Blood Pressure, Beta Blockers after a Heart Attack, Annual Monitoring of Medications, Part D Medication Adherence (diabetes, RAS antagonists, statins) and the administrative HEDIS Comprehensive Diabetic Care measure (CDC) is collected at the plan benefit package to measure that the appropriate clinical services are delivered for Jade SNP member's unique needs. The Medicare provider network, inclusive of SNP is monitored for availability of primary care providers, behavioral health providers and high volume specialists including nephrologists, ophthalmologists, gastroenterologists and surgeons important to members with chronic disease.

MOC 4.A.2 Specific data sources and performance measures used to continuously analyze, evaluate and report MOC quality performance.

The data sources and performance measures used to evaluate and report on the Model of Care are described here. Please see Table 4.1 for the specific measures, goals, timeframes and plan for re-measurement. Evaluation of the effectiveness of the SNP Model of Care occurs annually as part of the overall Health Net Quality Improvement Program. Metrics may be reported monthly, quarterly or annually depending on the established procedure for the specific metric. Standard processes for evaluating health outcomes, access, availability, member satisfaction, providers, utilization, etc. are followed along with new processes developed to allow for the analysis of unique SNP outcomes.

The following sources will be utilized to collect and analyze data as part of the annual evaluation of the SNP Model of Care to evaluate outcomes in each of the domains as specified in 422.152(g)(2)(i)-(x) of the Code of Federal Regulations (CFR):

- **Health Outcomes And Use Of Evidence Based Practices** – Health Care Effectiveness Data and Information Set (HEDIS®) measures, utilization metrics for access to ambulatory health services, behavioral health, ER visits, hospital readmits

- **Access to Care** – member surveys, appeals and grievances re: access, monitoring of provider network, utilization reports, HEDIS® preventive care metrics

- **Improvement in Health Status** – related HEDIS® measures, responses to HRA questions re: health status, pain, functional status, self-management

- **Implementation of Model of Care** – process reports from medical and behavioral health case management and delegation oversight

- **Health Risk Assessment** – initial and annual completion rates and refusals

- **Implementation of Care Plan** – audits of case management records and Care of Older Adults COA HEDIS® measure

- **Specialized Provider Network** – delegation oversight audits, availability of providers and facilities including behavioral health providers and specialists, member surveys, HEDIS® clinical measures

- **Continuum of Care** – related HEDIS® measures such as Medication Reconciliation, Plan All Cause Readmissions and Follow up after Hospitalization for Mental Illness and response to survey question regarding transitions

- **Delivery of Extra Services** – utilization for transportation, Decision Power, Complex Case Management, Medication Therapy Management program, dental and vision benefits

- **Integrated Communications**- Customer Call Center (service level, abandonment rate), satisfaction survey, website registration

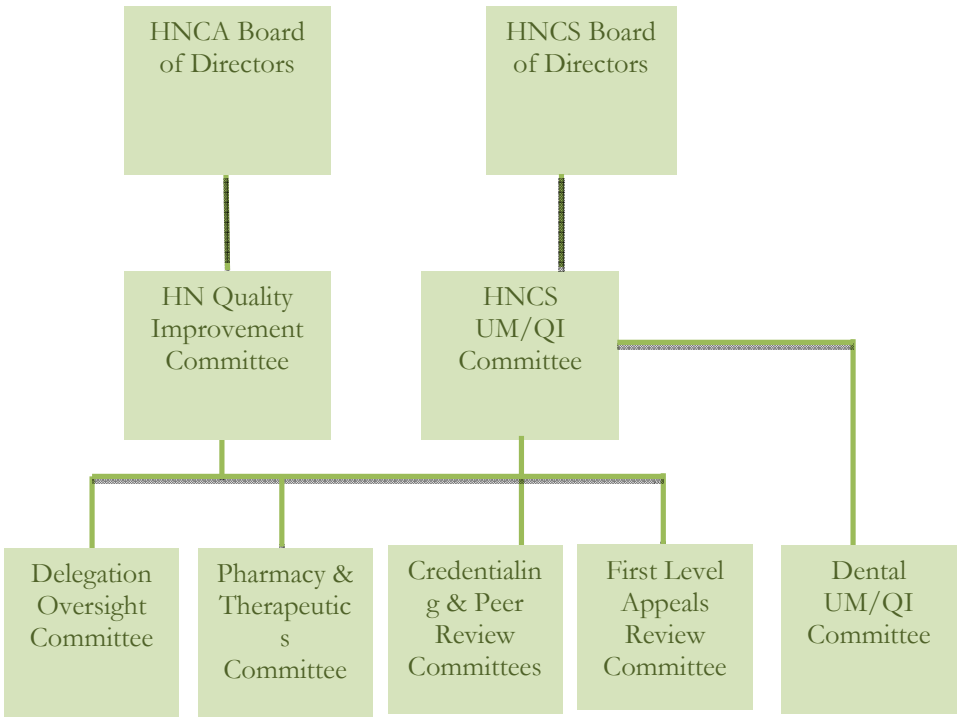
MOC 4.A.3 How leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process

The Health Net Board of Directors has ultimate authority and responsibility for oversight of the QI Program, including review and approval of the annual QI Program Description, Work Plan and Evaluation. The Board delegates the responsibility for implementing the QI Program to the Health Net Quality Improvement Committee (HNQIC) and the Health Net Community Solutions Utilization Management Quality Improvement (HNCS UM/QI) Committee.

Functions:

- Establish strategic direction for the QI Program
- Receive quarterly updates from Quality Management, and review reports from QI Committees, delineating actions taken and performance improvements at least annually
- Ensure the QI Program and Work Plan are implemented effectively and result in improvements in care and service
- Assess and recommend, as needed, resources to implement quality improvement activities

Health Net Quality Improvement Committee Organizational Chart



QI Committee Structure

Health Net has established a committee structure to foster quality improvement discussions and activities from multi-disciplinary areas to ensure compliance with regulatory and accreditation requirements across all regions. The structure of the Health Net committee promotes plan integration and provider network accountability for the identification, evaluation and measurement of key clinical and service activities.
The Quality Improvement Committee structure includes HNQIC, HNCS UM/QI Committee, and various sub-committees and workgroups. HNQIC and HNCS UM/QI Committees meet at least quarterly. Committees review and approve the QI Program Description, QI Workplan, and QI Annual Workplan Evaluation annually. Subcommittees meet regularly (usually quarterly), and workgroups are convened as needed at which time an appropriate meeting schedule is created. Quality Committee and sub-committee minutes are recorded at each meeting. Minutes include the topics and key discussion points, and planned actions/follow-up if needed.

1. Health Net Quality Improvement Committee

HNQIC has responsibility for oversight of the QI Program and is responsible for monitoring the quality and safety of care and services rendered to Commercial and Medicare Health Net members. The Committee is chaired by Regional Medical Director identified by the Chief Medical Officer and meets at least quarterly.

The HNQIC structure ensures practitioners participate in the planning, design, implementation, and review of the QI Program. External practitioners participate on HNQIC along with representatives from MHN, Health Net Pharmacy Services Network Management, Regional Medical Directors, Customer Service Operations, and Medical Management including Credentialing, Peer Review, and Utilization Management.

HNQIC Functions:

- Reviews and approves the Annual QI and UM Program Description, Work Plan and Evaluation
- Reports to the Board of Directors or Executive Management Team at least annually
- Recommends policy decisions, evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate
- Analyzes and evaluates the results of focused audits, studies, quality of care and safety issues and quality of service issues
- Monitors for compliance and other quality improvement findings that identify trends and opportunities for improvement

- Provides input and recommendations for corrective actions and monitoring previously identified opportunities for improvement including SNP Model of Care goals
- Oversees the CMS QI Program, receiving periodic reports on CMS-required QI activities
- Provides support and guidance to health plan associates on quality improvement priorities and projects
- Monitors data for opportunities to improve member and practitioner perception of satisfaction with quality of service

2. Health Net Community Solutions UM/QI Committee

The Health Net Community Solutions (HNCS) UM/QI Committee encompasses Health Net's Medi-Cal line of business and includes the Cal MediConnect dual eligible demonstration. The committee is charged with monitoring the medical management and quality of care and services rendered to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The HNCS UM/QI Committee is chaired by a Medical Director identified by the Chief Medical and Health Care Services Operations Officer and meets at least quarterly. The Dental UM/QI Committee reports to the HNCS UM/QI Committee and the HNCA Board of Directors. The Public Policy Committee includes Health Net members and provides regular reports to the HNCS UM/QI Committee.

HNCS UM/QI Committee Functions:

- Reviews and approves the Annual QI and UM Program Description, Work Plan and Evaluation
- Reports to the Health Net Community Solutions Board of Directors at least annually
- Recommends policy decisions
- Analyzes and evaluates the results of focused audits, studies, quality of care and safety issues and quality of service issues
- Monitors for compliance and other quality improvement findings that identify trends and opportunities for improvement
- Provides input and recommendations for corrective actions and monitoring previously identified opportunities for improvement
- Provides support and guidance to health plan associates on quality improvement priorities and projects including MMP model of care goals
- Monitors data for opportunities to improve member and practitioner perception of satisfaction with quality of service

3. QI Sub-Committees & Workgroups

The following subcommittees and workgroups provide ongoing updates to HNQIC and/or HNCS UM/QI Committee to ensure consistent decision making, share information and provide a mechanism for escalating issues.

Pharmacy & Therapeutics Committees (P & T)

The Health Net Pharmacy and Therapeutics (P&T) Committees are decision-making bodies that meet quarterly to develop and update the company's drug formulary, or drug list. The P&T Committees' primary goal is to assure continuous member access to quality-driven, rational, affordable drug benefits. The committee's members provide oversight for the development, implementation and maintenance of a national strategy to optimize pharmacotherapy that is cost-effective for members.

The Committee membership includes Health Net pharmacists and associates, and practicing pharmacists and physicians from the provider network. A Health Net Medical Director chairs the P&T Committee. Responsibilities include:

- Reviewing and approving policies that outline pharmaceutical restrictions, preferences, management procedures, delineation of recommended drug list exceptions, substitution/interchange, step-therapy protocols and adoption of pharmaceutical patient safety procedures
- Reviewing of pharmaceutical utilization and prescribing practice patterns
- Reviewing, revising and adopting of the Preferred Drug List (PDL) on an annual basis
- Reporting to Health Net Quality Committees at least annually

Credentialing & Peer Review Committees

The Health Net Credentialing Committees oversee the credentialing and re-credentialing process for delegated and non-delegated practitioners and providers. This process ensures that the networks of health care practitioners providing professional services to Health Net members are trained, licensed, qualified and meet criteria for participation in accordance with regulatory requirements and accreditation standards. The Committees review performance data and have final decision-making authority. The Credentialing Committees have representation from primary and specialty care participating practitioners. The committees are chaired by a Health Net Medical Director and meet at least quarterly.

Health Net's Peer Review Committees are responsible for decisions relating to quality of care and provide a forum for instituting corrective action when needed. The Peer Review Committees also assess the effectiveness of interventions through systematic follow-up. A Health Net Medical Director chairs each Peer Review Committee and meetings take place at least quarterly, or as deemed necessary by the Peer Review Committee Chairperson, to assure business is conducted timely. The members include representation from primary and specialty care practitioners and credentialing. Behavioral health representation is included on an ad hoc basis.

Delegation Oversight Committee (DOC)

The Delegation Oversight Committee is responsible for overseeing the formal process by which another entity is given the authority to perform functions on behalf of Health Net. The overall goal is to ensure that Health Net members receive comparable quality of care and service. The Delegation Oversight Committee meet at a minimum of monthly with additional meetings added as needed to meet the business requirements. Responsibilities include:

- Ensuring there is a contractual agreement between Health Net and the delegate, which outlines responsibilities, activities, reporting, evaluation process, and remedies for deficiencies
- Monitoring and evaluating a delegate's performance through routine reporting and an annual evaluation of the delegate's processes in compliance with all regulatory and accreditation standards
- Taking action if the monitoring reveals deficiencies in the delegate's processes
- Monitoring and evaluating a delegate's performance through due diligence prior to granting delegation

Medical Advisory Council (MAC)

Health Net's National Medical Advisory Council in conjunction with Centene's Corporate Clinical Policy Committee, is responsible for oversight of the formal process for the development and approval of medical policies, technology assessment, medical necessity criteria, clinical practice guidelines and preventive health guidelines. The MAC uses the principles of evidence based medicine to provide fair and impartial assessment of current medical and scientific literature of the effectiveness and appropriateness of procedures, devices, select drugs and biologicals. The MAC membership includes medical directors with a variety of specialties represented and other ancillary department representatives including medical management, legal and pharmacy and input is sought from physician experts as necessary. The MAC is chaired by the Vice President and Senior Medical Director and meets periodically throughout the year.

Dental UM/QI Committee

The Dental UM/QI Committee monitors utilization management and care coordination activities, and the quality of care and services rendered to Medi-Cal dental members. The committee identifies and selects opportunities for improvement and monitors interventions.

The Dental UM/QI Committee is chaired by the Dental Medical Director and meets at least quarterly, independently of the HNCS UM/QI Committee. The findings and action of the Dental UM/QI Committee's Quality Improvement Program are presented at the quarterly meetings of the HNCS UM/QI Committee and the HNCA Board of Directors. Annually the Dental Medical Director presents the written report on the status of dental

QI activities. The HNCS Committee approves the overall dental Quality Improvement System Manual (QIS) and the annual dental QIS report, directs the operational dental QIS to be modified on an ongoing basis.

Customer Experience Council and Steering Team

The Customer Experience Council (CX Council) and Steering Team is responsible for building and enhancing business capabilities to improve customer experience outcomes and is supported by a team of market researchers, Six Sigma Black/Green Belts, business analysts, program managers, change management and organizational development associates. The team monitors performance metrics around healthcare costs, clinical and service quality, employee engagement, membership retention and growth, and critical process-specific key performance indicators to tackle issues and facilitate changes. The council is chaired by the VP of Customer Experience and consists of members jointly accountable for achieving the customer experience objectives and initiatives that will be established each year or quarter as the program scales and refines targets. Each council member can be responsible for driving short and long term process and working teams, and reports to the monthly council meetings on project status, milestones, barriers, and progresses made.

Other:

QI Clinical & Service Workgroup

The QI Clinical and Service Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The workgroup also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety, access, services and member and provider satisfaction. The workgroup consists of a core group of QI associates, a consulting physician and ad-hoc members pertinent to the report topic. At each meeting, there is focused discussion on report findings, barriers, and interventions for the purpose of making and implementing decisions regarding QI activities. The QI Clinical and Service Workgroup meets at least twice per year and reports significant findings to the HNQIC and/or HNCS UM/QI Committee.

Other Committees and Workgroups:

Committees and workgroups are convened at Health Net to address specific products or requirements and may not report directly to the Quality Improvement Committee. Current examples include the Medi-Cal Governance Committee, the Medicare STARS Governance Committee and Provider Engagement Performance Management (PEPM) Governance Committee.

Key Associate Resources & Accountability

1. **Chief Medical Officer**

This position has responsibility for the QI and UM Programs and must assure that the Programs are compatible and interface appropriately with the provider network; oversee compliance with regulatory standards and reporting requirements; and achieve consistency in leading QI/UM operations. This individual has direct authority over California's Medical Management, Quality Improvement, Medical Directors and Behavioral Health.

2. Chief Medical Director – Medi-Cal

Chief Medical Director reports to the CMO for Medical Affairs for Medi-Cal and is responsible for development and implementation of strategies for access to care, improved quality outcomes, regulatory compliance and cost of care management. Reporting to Chief Medical Director will be designated Medi-Cal medical directors and the Director of Tele-health. In this role, the Chief Medical Director will work closely with the Medical Affairs and Management teams, and cross-functional teams to create a culture of quality and accomplish the goals of the Triple Aim (Better Health. Better Care. Lower Cost)

3. Medical Director QI

The Medical and Health Care Services Operations Officer designates a Medical Director to provide clinical and administrative physician leadership to the QI Program, including:

- Oversight of the development, implementation and evaluation of QI projects and population based care programs.
- Physician leadership for NCQA and regulatory agency surveys/audits.
- Represents Health Net as the physician QI liaison to external organizations, as needed.
- Chair Health Net Quality Committees

4. Vice President Quality Management

The VP of Quality Management reports directly to the Medical and Health Care Services Operation Officer and is responsible for the overall direction and management of the QI Program, including:

- Organization wide QI outcomes and compliance with regulatory and accreditation bodies.
- Successful Accreditation outcomes for all applicable regions and product lines
- Oversight of delegation to ensure performance meets established standards for quality and cost-effective delivery of healthcare services
- Overall HEDIS® operations and performance
- Credentialing and Peer Review activities to ensure criteria for practitioner performance is measured and acted upon in a timely and consistent manner.

- Wellness, Health Education and Cultural & Linguistic program and services are developed and implemented for all members

5. Behavioral Health Medical Director

The MHN Medical Director is involved with the behavioral health care aspects of the QI program, including participation on the MHN QI/UM Committee, HNQIC, HNCS UM/QI and evaluating continuity and coordination of care between behavioral and medical health, triage and referral process and access/availability performance to ensure that a close, coordinated approach to provision of behavioral health services and coordination of care with medical services is in place.

6. Medical Directors

The Medical Directors are licensed physicians responsible and accountable for assuring appropriate clinical relevance and focus of the Utilization and Care Management and QI Programs for all lines of business. The Medical Directors interface with providers and individual practitioners and facilities to ensure the performance of the provider community meets established Health Net standards. The Medical Directors participate in HNQIC, HNCS UMQI Committee and other QI activities.

7. Director of Quality Improvement

The Commercial/Medicare and Medi-Cal Directors of Quality Improvement report to the VP of Quality Management. Responsibilities related to the QI Program include:

- Overall management of the QI Program including the behavioral health QI program
- Resolves barriers that prevent appropriate monitoring of quality of care and quality of services
- Assures implementation of quality improvement activities
- Reviews reports, identifying issues, formulating policies and procedures and makes recommendations to the QI committees
- Provides consultation to Quality Management associates
- Maintains accreditation and QI compliance
- Direct and lead a cross functional Health Net team, identifying and ensuring action is taken on priorities, leveraging relationships and leading to affect appropriate and substantive interventions among leaders.
- Continuously assess the data and information available on Medicare STAR performance, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Manage vendor relationships as necessary to support the processes to improve STARS performance.

8. Director Of Data Analysis

The Director of Data Analysis reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Assure identification of opportunities for quality improvement activities, related to achieving quality outcomes (Stars, NCQA accreditation, member satisfaction, etc.).
- Review reports and guide the analytic approach across all lines of business, and make recommendations to QI Committees.
- Assure implementation of quality improvement metrics and outcome measures.
- Ensure delivery of in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement.
- Continuously assess the data and information available on Medicare STAR performance, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Ensure collaboration with HEDIS staff to identify areas of opportunity.
- Provide feedback on Quality outcomes and progress to Corporate and Market leadership.

9. Quality Improvement Managers

Both Health Net and MHN Quality Improvement Managers report to the Director of Quality Improvement. Responsibilities related to the QI Program include:

- Implements the structural components of the QI Program
- Maintains accreditation and compliance to QI requirements
- Organizes and directs activities designed to illustrate process improvement
- Oversight and management of rating programs such as Medicare Stars, Commercial and Exchange OPA Stars and Medi-Cal External Accountability Set (EAS)
- Oversee Facility Site Review and identifies issues regarding PCP and High Volume Specialty providers (including BH, Ancillary and CBAS) facility's physical accessibility.

10. Quality Improvement Research & Analysis Manager

The Quality Improvement Research & Analysis Manager reports to the Director of Data Analysis. Responsibilities related to the QI Program include:

- Assures implementation of quality improvement metrics and outcome measures
- Conducts an in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement

- Identifies data to be collected for selected studies and reviews format and methodology for appropriateness. Evaluates and analyzes relevant findings

11. Quality Analytics Program Managers

Quality Analytics Program Managers are responsible for identifying, managing and tracking clinical, quality, correct coding, documentation and data submission projects that advance the objectives of Health Net's strategic goals.

Responsibilities include:

- Working across functional teams to develop performance trackers and tools as needed to meet national performance targets and drive quality improvement.
- Addressing the DHCS Corrective Action Plan (Medi-Cal), Medicare Stars ratings, and Undertakings requirements (commercial) by providing insight through statistical analysis of utilization and member data to identify opportunity areas that inform QI intervention.
- Facilitating the development of internal and external reports and the delivery of data as needed to support and monitor the action plans to accomplish the Triple Aim: 1) to improve member experience, 2) improve the quality of care and 3) to reduce health care costs.

12 Quality Improvement Analysts

The Quality Improvement Analysts reporting under the Quality Analytics Program Managers conduct in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement.

Responsibilities include:

- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.
- Review and assist in study design/methodology and provide data to be utilized for QI studies to meet regulatory requirements.
- Review and analyze the study findings and recommend corrective actions and next-steps.
- Establish and implement programs and initiatives to meet NCQA requirements.
- Continuously assess the data and information available on plan performance, to identify trends and risk areas.
- Provide support, guidance and collaboration to stakeholders in other Health Net Departments to assure implementation, analysis and follow-up of activities.

12. Quality Improvement (QI) Specialists

Senior QI Specialists have RN licenses or are Masters/PhD educated employees who implement quality improvement initiatives and studies for Health Net through multi-disciplinary workgroups designed to address clinical and service issues to meet all regulatory and accreditation requirements. Responsibilities include:

- Conducts the evaluation and review of the effectiveness of the QI Program and prepares documents for submission to the QI Committees, Executive Management Team and the Board of Directors
- Provides support, guidance and collaboration to Health Net departments to assure implementation, analysis and follow-up of activities per the QI Work Plan
- Reviews and/or revises policies and procedures on an annual basis, or as necessary
- Identifies data to be collected for selected studies and reviews format and methodology for appropriateness. Reviews and analyzes the findings and recommends corrective actions and re-measurement as applicable
- Establishes and implements programs and initiatives to meet NCQA requirements
- Maintains regulatory compliance
- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.

13. Director Of Health Education/Wellness/Cultural And Linguistic Services

The Director of Health Education/Wellness/Cultural and Linguistic Services reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Overall management of the health education, wellness and cultural and linguistic related programs including health disparities reduction efforts.
- Direct and oversee department-led interventions and programs that address HEDIS® measures and identify and ensure action is taken on priorities.
- Review reports, identify issues, formulate policies and procedures and make recommendations to the QI committees.
- Provide consultation to Quality Management associates.

MOC 4.A.4 How SNP specific measureable goals and health outcomes are integrated into the overall performance improvement plan.

The SNP Quality Improvement Program is part of the overall Health Net Quality Improvement Program. The QI Program establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction. Quality improvement activities are selected based on areas identified for improvement through data collection and monitoring and the following program goals:

- Support Health Net's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations or 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.
- Establish, implement and continually evaluate the effectiveness of a written quality improvement plan that analyzes internal organizational performance measures and takes action to maintain and/or improve 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 disease management programs.
- Monitor and improve Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of practitioner and member satisfaction surveys, focused studies, and analysis of administrative data; emphasizing administrative, primary care, high-volume specialists/specialty services, and behavioral health/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 resolutions of perceived failure by practitioner/providers or Health Net personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate

Established quality improvement activities implemented to improve health outcomes, access and member satisfaction are inclusive of SNP members and new activities are developed as a result of analysis of SNP specific data and guidance from the HNQIC. SNP specific measureable

goals and outcomes are integrated into the QI Workplan. Some examples of activities integrated into the overall performance improvement plan to meet SNP specific goals and health outcome objectives include:

- Quality Improvement Project to Prevent Diabetes
- Chronic Care Improvement Program to Promote Appropriate Osteoporosis Management for Older Women
- Medication Therapy Management program with quarterly medication reviews, appropriate provider and member interventions including access to a pharmacist
- High Risk Drugs to Avoid in the Elderly Program
- Medication Adherence to Improve Cardiac Health
- Decrease the use of Multiple Narcotics and High Dose Tylenol
- Promote Preventive Care: initiatives to improve flu/pneumonia vaccine, breast cancer screening, colorectal cancer screening, diabetic retinal exam
- Activities to Improve Diabetic Care measures

Data collected from HEDIS®, CAPHS®, surveys, HRA, audits, appeals and grievance, utilization, customer service and other sources will be used to evaluate if the Jade SNP met the specific and measureable goals within a certain timeframe as described in Table 4.1 (please see MOC 4.B.2). These measurable goals are identified based on the overarching healthcare domains of the overall quality performance improvement plan (as detailed in MOC 4.A.2) and the previously mentioned program objectives relevant to the SNP population. Outcomes are compared to applicable and available benchmarks from internal and external sources such as NCQA, CMS, Medicare Advantage and SNP member data. Each goal as stated in Table 4.1 will be compared to the previous year's performance and to the measurable specific goal and designated as "met" or "unmet" as part of the annual SNP MOC evaluation.

The results of the annual SNP MOC evaluation are reported to stakeholders and HNQIC and their recommendations are considered in determining quality improvement activities, projects and specialized services and benefits to improve performance. Actions taken when program goals are not met will vary according to specific metrics, goals and affected departments. Please see MOC 4.B.5 for more details regarding plan for re-measurement of goals. Moreover, additional areas for potential improvement will be prioritized based on compliance with regulatory guidelines, NCQA standards, performance as compared to the reference value and the ability to effectively address identified barriers.

MOC 4.B MEASURABLE GOALS AND HEALTH OUTCOMES

MOC 4.B.1 Identify and define the measurable goals and health outcomes used to improve the healthcare needs of SNP members

Overall the goals for the SNP Model of Care as stated by the Center for Medicare and Medicaid Services are to improve health outcomes through:

- Improved access to essential services such as medical, mental health and social services
  - Improving access to affordable care
  - Improved coordination of care through an identified point of contact
  - Improving seamless transitions of care across health care settings, providers and health services
  - Improving access to preventive health services
  - Assuring appropriate utilization of services
  - Improved beneficiary health outcomes

MOC 4.B.2 Identify specific member health outcomes measures used to measure overall SNP population health outcomes at the plan level

As part of the annual SNP evaluation, data is collected from HEDIS®, CAPHS®, surveys, HRA, audits, appeals and grievance, utilization, customer service and other sources for a comprehensive set of metrics in each healthcare domain (as detailed in MOC 4.A.2) and to meet requirements in 422.152(g)(2)(i)-(x) of the Code of Federal Regulations (CFR). Outcomes are compared to applicable and available benchmarks from internal and external sources such as NCQA, CMS, Medicare Advantage and SNP member data. A subset of metrics is identified for each of the program objectives that are relevant to the SNP population and re-evaluated each year. Measureable goals are set based on baseline performance and reference values within a certain timeframe (Table 4.1). Results will be compared year to year and to measure specific benchmarks that are available.

Table 4.1

DATA SOURCE	MEASURABLE GOALS AND TIMEFRAME
Improved Access to Essential Services: Medical, Mental Health and Social Services	
SNP Satisfaction Survey	Rate for "Always/Usually" will increase by 1% or achieve 83% for Q12 "In the last 12 months, not counting the times you needed emergency care, how often did you get that appointment as soon as you thought you needed?" in measurement year
HEDIS®	Percent of members with access to preventive or ambulatory health services (AAP) will achieve 93% in measurement year

Improved Access to Affordable Care	
SNP Satisfaction Survey	Rate for "Always/Usually" will increase by 2% or achieve 70% for Q6 "How often did your case manager give you phone numbers or names of other groups to help you meet your health needs? In measurement year
Improved Coordination of Care Through an Identified Point of Contact	
SNP Part C Report	Overall completion of HRA (initial and reassessment) will improve by 3% or meet National Part C Average* of 69% in measurement year
SNP Satisfaction Survey	Rate for "Always/Usually" will increase by 2% or achieve 70% for Q6 "How often did your case manager give you phone numbers or names of other groups to help you meet your health needs? In measurement year
Improving Seamless Transitions of Care Across Health Care Settings, Providers and Health Services	
SNP Satisfaction Survey	Members responding “Yes” to “Did you have the information you needed upon discharge regarding medications and follow-up care?" will improve by 1% or meet 85% in measurement year
HEDIS®	Members with Medication Reconciliation documented post-discharge will improve by 2% or meet the National Part C Average of 50% in measurement year
Improved Access To Preventive Health Services	
HRA	Continuing members reporting obtaining Flu Vaccine will improve by 1% or meet National Part C Average of 71% in measurement year
HEDIS®	Rate for Comprehensive Diabetes Care - Diabetic Retinal Exam will improve by 1% or meet National Part C Average of 72% in measurement year
Assuring Appropriate Utilization of Services	
HEDIS®	Rate for Emergency Department Utilization (AMB ED) will decrease from previous year
HEDIS®	All Cause Readmission rate in 30 days (>65 years) will decrease by 0.5% or meet National Part C Average of 10% in measurement year
Improving Beneficiary Health Outcomes	
HEDIS®	Rate for High Risk Drugs in the Elderly (1 drug) will improve by 1% or meet Quality Compass Medicare Average of 11% in measurement year
HEDIS®	Rate for Osteoporosis Management will improve by 1% or meet National Part C Average of 41% in the measurement year
HEDIS®	Rate for Controlling Blood Pressure will improve by 1% or meet National Part C Average of 72% in the measurement year

National Part C Averages from 2018 Star Ratings Technical Notes (9/2017)

MOC 4.B.3 How methods are established to assess and track the MOC's impact on SNP member health outcomes

As a Medicare Advantage Organization, Health Net is required to collect and report annual Health Care Effectiveness Data and Information Set (HEDIS®), including the SNP specific HEDIS® metrics as directed in Chapter 5 of the Medicare Managed Care Manual. Health Net contracts with a NCQA-certified software vendor to produce the HEDIS® measures. The vendor follows the NCQA Technical Specifications and applicable Technical Update to define the eligible population/denominator and numerator compliance through proprietary software certified annually by NCQA. The HEDIS® reporting process is audited by an NCQA-licensed audit firm.

For HEDIS® reporting, Health Net obtains and provides pharmacy, claims, encounter, membership, provider and other supplemental data to the software vendor through a secure FTP transmission process. The submission of data is reconciled from Health Net to the software vendor through an access database called the Data Tracking Tool which ensures data has been transmitted correctly and completely to the software vendor. The data is then loaded into the certified software product. The specifics of the loads are documented on the Check Figure Report which contains a listing of all data received. The report is reviewed by Health Net for accuracy and completeness.

As required by CMS and state agencies, Health Net's HEDIS reporting activities must undergo an audit by an NCQA-certified HEDIS Compliance Audit Firm. Health Net contracts with an NCQA-licensed audit firm to conduct the audit. The HEDIS audit program verifies that Health Net's HEDIS production conforms to the Technical Specifications.

Health Net is also required to contract with an NCQA-certified vendor to conduct the Medicare Consumer Assessment of Health Care Providers and Systems (CAHPS®) Study for Medicare members as outlined in the CMS Chapter 5 of the Medicare and Managed Care Manual. CAHPS® is an annual nationwide survey that is used to report information on Medicare beneficiaries' experience with managed care plans. Health Net receives written notification from CMS of the timeline in which the surveys are conducted, the number of surveys and the expected number of Medicare members who will receive a survey. CAHPS® data are made available to all stakeholders. The results are shared with Medicare beneficiaries and the public.

As described in MOC 4.B.2, relevant measures are selected that will have an impact on the health outcomes of SNP members, such as improvement in diabetic and cardiovascular health outcomes, preventive care and coordination of care. Health Net has established processes and contracts with vendors when appropriate to collect SNP health outcome data through HEDIS® and annual HRAs, member experience and access to care through CAHPS® and internal surveys, and data from provider network, delegation oversight, utilization of services, customer service, communication systems and transitions of care through internal information systems and audits of case management and concurrent review files. Data is collected according to the established process for the individual metric and could be monthly, quarterly or annually as with HEDIS® and CAHPS®.

The SNP member health outcomes from each of these measures are compared year to year and with available benchmarks and/or goals as part of the annual evaluation of the SNP MOC. Annual data and progress towards goals is collected, analyzed and reported to the HNQIC and stakeholders. Electronic and print copies of the evaluation of the SNP Model of Care will be prepared annually, reported to the HNQIC and as requested, to regulatory and accreditation organizations and preserved as an official record. The complete document includes quantifiable measures, quantitative and qualitative analysis, barrier and opportunity analysis, actions taken to address barriers, goals met/unmet and data definitions.

MOC 4.B.4 Describe the processes and procedures the SNP will use to determine if health outcomes goals are met

The SNP member health outcomes from each of these measures are compared year to year and with available benchmarks and/or goals as part of the annual evaluation of the SNP MOC. Annual data and progress towards goals is collected, analyzed and reported to the HNQIC and stakeholders. Established processes to collect outcomes are described in MOC.4.B.3. In the annual MOC evaluation, each goal as stated in Table 4.1 is compared to the previous year's performance and to the measurable specific goal and designated as "met" or "unmet".

Health Net also completes the SNP MOC Plan Performance Monitoring and Evaluation (PPME) database annually as required by CMS that includes the measures, time frames, re-measurement, goals met/unmet and if Corrective Action plan taken.

MOC 4.B.5 Describe steps taken if goals not met in expected time frame

As stated in MOC 4.A.3, Health Net has established a committee structure to foster quality improvement discussions and activities from multi-disciplinary areas to ensure compliance with regulatory and accreditation requirements across all regions. One of the functions of the committee structure is to provide input and recommendations for corrective actions and monitoring previously identified opportunities for improvement. The structure of the Health Net committees promotes plan integration and provider network accountability for the identification, evaluation and measurement of key clinical and service activities. The results of the annual SNP MOC evaluation including "met" and "unmet" goals are reported to stakeholders and HNQIC and their recommendations are considered in determining quality improvement activities, projects and specialized services and benefits to improve performance. Actions taken when program goals are not met are documented in the annual SNP evaluation and will vary according to specific metrics, goals and affected departments.

Outcomes from the HEDIS®, CAHPS®, HRA, Medication Therapy Management (MTMP), utilization, communication systems and other program indices are analyzed at least annually. Action taken for metrics that do not meet goals can include Quality Improvement Projects or activities such as member outreach, provider education or system and process changes designed to impact the measure outcomes and improve care or service. Interventions can include automated or livecalls, newsletters, health calendars, emails, and educational materials designed to improve Flu/Pneumonia Vaccination, diabetes care, colorectal cancer screening,

cardiac health and member satisfaction. Below is an example from the annual SNP MOC of actions taken when the goal for diabetic eye exam was not met.

Members obtaining Diabetic Retinal Exam will improve by 1% or meet National Part C Average of 70%	• Mailer on steps to access vision care and importance of annual eye exam sent to 15K members with a care gap in Qtr 3 • Provider report cards on current performance on this measure provided and discussed during JOMs • PPG teleconference on 5/18/16, on Diabetes attended by 201 • 2016 Health Planner/Calendar mailed to all Medicare members Qtr 4 promotes annual eye exam • IVR call to members with care gap in July/2016 provided education and encourages annual eye exam • Live calls to 1K members with multi-gaps in care in Qtr 4

Health Net also investigates and requests corrective actions when timely access to care, as required by Health Net's Access and Availability policies, is not met. Based on CAHPS® results, Health Net has provided doctor's offices with educational newsletters, after-hours provider script, and a patient experience toolkit with materials in multiple languages for improving access to care. Results of access monitoring through surveys and appeals and grievance data and applicable actions for improvement are communicated to the Health Net Quality Improvement Committee (HNQIC) for review and approval.

Health Net also conducts a structured pre-delegation evaluation to include analysis of program documents, audit of related files and an on-site review of the SNP delegated group's operations. The evaluation results are compiled and a written summary of the findings and recommendations are presented to the Delegation Oversight Committee for final determination. This type of audit is also performed annually, at a minimum, to determine the continuation of the delegated relationship. Delegated groups that do not meet the SNP program requirements are de-delegated.

MOC 4.C. MEASURING PATIENT EXPERIENCE OF CARE (SNP MEMBER SATISFACTION)

MOC 4.C.1 Describe the specific SNP survey used.

Health Net has collaborated with a CAHPS® certified vendor to develop and conduct a survey to assess the experience of the SNP population with the Case Management program. This SNP satisfaction survey asks members to rate their experience with: their Case Manager, care coordination between case manager and provider, access, and ease of obtaining appointments. A random sample of eligible SNP members is selected to participate in the SNP Satisfaction survey annually in Q3. The administered survey should take no longer than ten minutes to complete and the goal is to complete 400 member surveys. The response rate is monitored to collect an adequate sample size. The questionnaire is programmed in English and Spanish into the Computer Assisted Telephone Interview (CATI) system, and bilingual interviewers will conduct the survey via the telephone. At least three call attempts will be made to reach respondents. The survey results are produced for each region and stratified by SNP type (D-SNP vs. C-SNP).

Table 4.2 details survey questions asked of SNP members regarding member satisfaction.

Table 4.2

QUESTIONS
Q1. Have you received help from a case manager or health team member in the past 12 months? This help could be from someone in your doctor office or from Health Net.
Q2. How often did the case manager or health team help you get the doctor visits or services you needed?
Q3a. How often was the help from your case manager to meet your health needs easy to understand and follow? Q3b. How often did your case manager or health team treat you with courtesy and respect? Q3c. How often did your case manager or health team give you the help you needed for your health needs?
Q4. How often did you make changes that improved your health because of help from your case manager or health team?
Q5. How often was any written health information from your case manager or health team useful and easy to follow?
Q6. How often did your case manager give you phone numbers or names of other groups to help you meet your health needs?
Q7. What is your overall satisfaction with the case management program?
Q8. How likely are you to get a flu shot or test for cancer because the case manager or health team asked you to?
Q9. How likely are you to take your medications regularly because of help from the case manager or health team?
Q10a. How would you describe your ability to understand what your doctor tells you? Q10b. How would you describe your ability to follow what your doctor tells you?
Q11. In the last 12 months, not counting the times you needed emergency care, did you make any appointments for your health care at a doctor's office or clinic?
Q12. In the last 12 months, not counting the times you needed emergency care, how often did you get that appointment as soon as you thought you needed?
Q13a. In the last 12 months, did you get care from more than one kind of health care provider or use more than one kind of health care service? Q13b. In the last 12 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?

QUESTIONS
Q14. In the last 12 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
Q15. Specialists are doctors like surgeons, heart doctors, allergy doctors, psychiatrists, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make appointments to see a specialist?
Q16. In the last 12 months, how often was it easy to get appointments with specialists?
Q17. If you were discharged from a hospital or nursing home in the past year, did you have the information you needed regarding medications and follow-up care?

MOC 4.C.2 Explain the rationale for the selection of a specific tool.

The tool as described in the previous section was selected because it allowed Health Net to have input into the design of the questions and survey methodology. Questions were framed to evaluate member experience with the case management program and impact on member health. Additional questions were added to obtain data specific to SNP access to care. The survey measures if specific program goals are being met to identify processes for improvement.

MOC 4.C.3 Describe how results of patient experience surveys are integrated into the overall MOC performance improvement plan

The vendor for the patient experience survey completes a quantitative and qualitative analysis and report of barriers and opportunities based on member's survey responses and compared to the previous year. Outcomes are communicated to case management, delegation oversight, providers and additional departments. Health Net evaluates the report, identifies barriers and opportunities and plans interventions to address barriers and improve outcomes. The survey outcomes are integrated into the annual evaluation of the SNP Model of Care and measurable goals are developed for the Plan Performance Monitoring and Evaluation document (PPME). Please see MOC 4.C.4 for more details regarding next steps.

MOC 4.C.4 Describe steps taken by the SNP to address issues identified on survey response

The vendor completing the SNP program satisfaction survey provides an annual report designed to determine strengths, weaknesses, and priorities for improvement as well as to monitor the results of improvement efforts over time. After the barrier analysis is conducted, low scoring areas will be incorporated into action plans to improve member experience with case management such as educational programs to improve communication, coordination of care, knowledge of community resources, changes in staffing and use of motivational interviewing to

change health behaviors. The table below from the annual evaluation describes actions taken to address member survey responses regarding getting information to meet health needs.

Got information needed to meet health needs will increase by 2% or ≥ 70%	• Staffing increased to provide Case Management in-house instead of through vendor - standardizes processes to provide member information • Change to new case management documentation platform as part of transition activities in Qtr 3 • Articles in 2017 Health Planner/Calendar mailed to about 243K members in Nov/2016 provides resources to obtain information

4D. ONGOING PERFORMANCE IMPROVEMENT OF THE MOC

MOC 4.D.1 How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC

The annual evaluation of the SNP MOC identifies clinical and nonclinical outcomes that could be improved to better meet the needs of SNP members. Results could be used to provide improved educational materials or new and innovative methods of member and provider outreach to improve preventive and chronic care health outcomes such as increasing adherence to diabetic and cardiovascular drugs, obtaining annual diabetic eye exam and obtaining the flu vaccine.

Case Managers can gain a better understanding of how to meet member needs from the responses on the member SNP satisfaction survey such as accessing care and making health behavior changes. Changes have also been made to the medical information management system to allow more efficient completion of HRA surveys and development of the individualized care plan for the member and ICT. Changes and additions to benefit design specific to SNP members such as zero cost sharing for select cardiovascular or diabetic drugs, improved dental benefits, or increase in the number of trips for the free medical transportation benefit could also be made.

MOC 4.D.2 How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality

The analyzed results of the effectiveness of the SNP MOC are collected and reported annually. Individual interventions that are implemented to improve select measures are re-evaluated for effectiveness when goals are not met and new interventions may be developed based on best practices. Additionally, new metrics may be identified for potential improvement as part of the annual evaluation of the SNP MOC when they decline or are below the available reference value. The potential areas for improvement identified through data collection are prioritized based on compliance with regulatory guidelines, NCQA standards, performance as compared to the reference value and the ability to effectively address identified barriers. Potential new measures to be targeted for improvement based on the annual evaluation of the SNP MOC is included in the annual report. New and revised goals to continuously improve the MOC are based on the data analysis and documented in the annual SNP MOC evaluation.

MOC 4.D.3 The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

Multiple data sources are utilized to evaluate the SNP MOC that are collected and acted upon by various departments. Data is collected at intervals that allow timely intervention by the affected department. For example, the customer service department evaluates their ability to answer calls in a timely manner on a daily, weekly and monthly basis and has a back-up system in place to make immediate adjustments when performance goals are not being met. They also anticipate the need for an increase staffing during times of high call volume such as annual enrollment. The pharmacy department monitors performance for medication adherence and drugs to avoid in the elderly on a monthly basis and provides timely interventions with members and/or providers when care gaps are identified.

Health Net also produces and communicates to providers year to date reports on HEDIS measures in order to obtain continuous performance results, instead of annual, for the HEDIS and pharmacy metrics. This supports timely evaluation of the effectiveness of health plan and provider interventions and taking action for performance that is not meeting the expected targets and goals.

MOC 4.D.4 How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders

The annual SNP MOC evaluation and progress towards goals is documented and reported to the Health Net Quality Improvement Committee (HNQIC) which includes internal and external stakeholders such as providers and leadership from key departments. HNQIC is composed of internal and external providers, management and leadership of key departments responsible for implementation of the SNP Program such as case management, disease management, delegation oversight, cultural and linguistic program, program accreditation, contracting, appeals and grievances, research and analysis, and credentialing.

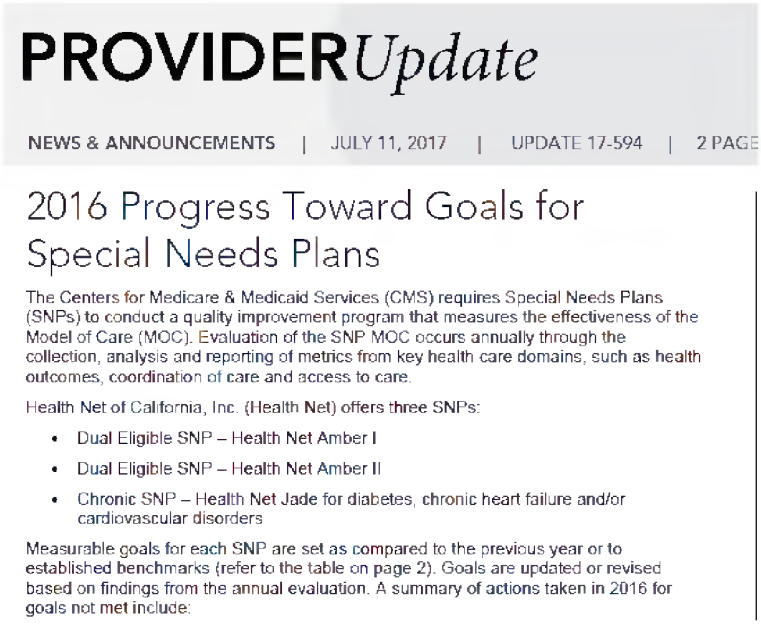
Results of the data analysis and recommendations of HNQIC are considered in determining quality improvement activities, projects and specialized services and benefits. In addition, program outcomes are communicated during annual provider webinars and attendees have the opportunity to ask questions or provide feedback. Providers also represent and communicate member issues at HNQIC and during regularly scheduled operational meetings. Electronic and print copies of the evaluation of the SNP Model of Care is prepared annually, reported to the HNQIC and as requested, to regulatory and accreditation organizations and is recorded in the minutes and preserved as an official record.

MOC 4.E. DISSEMINATION OF SNP QUALITY PERFORMANCE OF THE MOC

MOC 4.E.1 Describe how performance results are shared with multiple stakeholders

Providers and members are informed of outcomes through educational programs, meetings, updates, newsletters, and provider and member portal online articles. The Medicare

Newsletter includes, "Health Net's Commitment to Quality" informing members of Health Net's progress towards goals for key HEDIS® and Customer Satisfaction metrics including improvement from the previous year and comparison to national benchmarks. The SNP specific HEDIS® Care of Older Adults metrics are included. A Provider Update also summarizes the SNP MOC evaluation and progress towards goals.



PROVIDER*Update*

NEWS & ANNOUNCEMENTS | JULY 11, 2017 | UPDATE 17-594 | 2 PAGE

2016 Progress Toward Goals for Special Needs Plans

The Centers for Medicare & Medicaid Services (CMS) requires Special Needs Plans (SNPs) to conduct a quality improvement program that measures the effectiveness of the Model of Care (MOC). Evaluation of the SNP MOC occurs annually through the collection, analysis and reporting of metrics from key health care domains, such as health outcomes, coordination of care and access to care.

Health Net of California, Inc. (Health Net) offers three SNPs:

- Dual Eligible SNP – Health Net Amber I
- Dual Eligible SNP – Health Net Amber II
- Chronic SNP – Health Net Jade for diabetes, chronic heart failure and/or cardiovascular disorders

Measurable goals for each SNP are set as compared to the previous year or to established benchmarks (refer to the table on page 2). Goals are updated or revised based on findings from the annual evaluation. A summary of actions taken in 2016 for goals not met include:

Provider communications throughout the year inform providers of the outcomes of the quality improvement program and projects. Provider webinars on various topics are conducted and can include information on quality outcomes for measures regarding preventive care, behavioral health, chronic disease management and member satisfaction. Provider meetings are scheduled regularly throughout the year and "Report Cards" are discussed with the medical group's performance on quality metrics and resources available to improve performance.

The annual SNP MOC evaluation and progress towards goals is documented and reported to the Health Net Quality Improvement Committee (HNQIC) which includes internal and external stakeholders such as providers and leadership from key departments. HNQIC is composed of internal and external providers, management and leadership of key departments responsible for implementation of the SNP Program such as case management, disease management, delegation oversight, cultural and linguistic program, program accreditation, contracting, appeals and grievances, research and analysis, and credentialing. Member advisory committees for public programs solicit member feedback.

MOC 4.E.2 State the scheduled frequency of communication with stakeholders

- Annual webinars are conducted with Provider Groups on varied program outcomes and progress towards goals. Results from quality measures related to preventive care, chronic disease management, behavioral health, care transitions and member satisfaction are reviewed according to the webinar topic.

- The annual SNP Program Evaluation is reported to the HNQIC committee comprised of multiple internal and external stakeholders. In addition to the outcomes, the report includes a barrier analysis, opportunities and summary of interventions to address low performance.
- A Provider Update is produced annually summarizing the SNP MOC evaluation and progress towards goals.
- A summary of the SNP MOC Goals is presented annually to the Health Net Board of Directors.
- An Online News article, "Quality Improvement Outcomes and Progress" is published annually for providers and includes key outcomes compared to the previous year and to national standards for multiple lines of business. Examples of the measures of clinical care included in the online news article are: Advance Care Planning, Functional Assessment, Medication Review, and Pain Assessment.
- The Medicare newsletter article, "Health Net's Commitment to Quality" informs members of Health Net's progress towards the goal of improving care and outcomes and is produced annually. Categories include: Measures of Clinical Care, Service, and Health Outcomes.

MOC 4.E.3 Describe the methods for ad hoc communication with stakeholders

- Ad hoc online provider e-mail alerts and faxed communications are produced periodically throughout the year to provide updates on a variety of topics or quality initiatives. The communications are developed by the QI, Pharmacy or other departments and disseminated by Provider Communications or Provider Network Management.
- Additional provider communication and education is provided by QI employees on varied topics such as coordination of care, preventive care, etc during regularly occurring operational meetings (usually quarterly) with Regional Medical Directors and provider groups.
- Provider webinars (6) are scheduled on varied topics around chronic disease management, behavioral health, preventive care and other relevant topics. Topics for the webinars change each year according to the initiatives targeted for improvement as a result of ongoing data collection and monitoring. At each webinar, providers are encouraged and given the opportunity to ask questions or share observations or best practices.

MOC 4.E.4 Identify the individuals responsible for communicating performance updates in a timely manner

Health Net has provided extensive resources to the SNP program to meet the comprehensive data collection, analysis, evaluation and communication requirements. The Medicare QI Manager, BSN, CPHQ leads a team of 8 Senior QI Specialists and Program Managers with

nursing and/or advanced public health backgrounds. SNP members are incorporated into the initiatives to improve healthcare outcomes for all Medicare members including improving diabetic and cardiovascular measures, the Chronic Care Improvement Program (CCIP) and the Quality Improvement Programs (QIP).. The Medicare QI Manager or delegate annually reports SNP progress towards goals to the HNQIC and to stakeholders through Provider webinars. Senior QI Specialists develop the Provider Update, online news article and Medicare newsletter article annually reporting clinical outcomes.

The QI Research and Analysis (QIRA) team includes Doctoral, Master or Bachelor prepared Research Analysts in Public Health, Biostatistics, Epidemiology and Business Economics. The QIRA team also participates in the data collection, analysis and SNP program evaluation and the QIRA Manager presents reports to the HNQIC on integrated member satisfaction, access and availability and epidemiological reports.

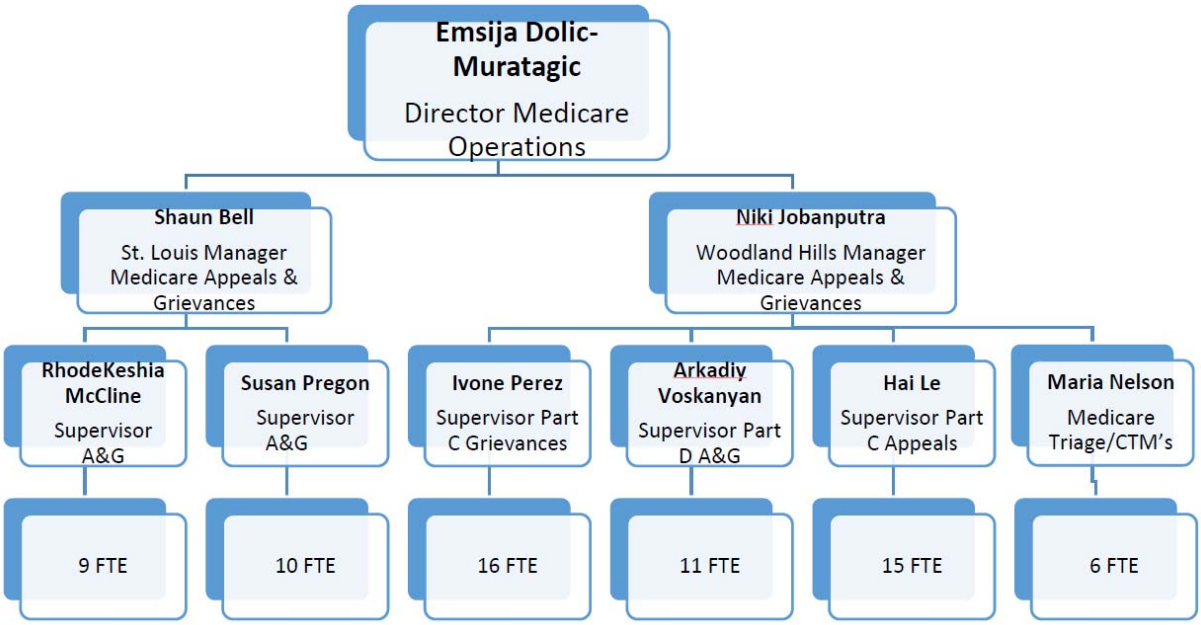
The QI Director holds a Masters in Exercise Studies and a Bachelor of Science in Physical and Health Education. She has multiple years of experience with the Medicare, Stars and SNP programs and provides resources and guidance for the QI Medicare Manager and communicates updates on the SNP MOC evaluation to the Board of Directors.

ORGANIZATIONAL CHARTS

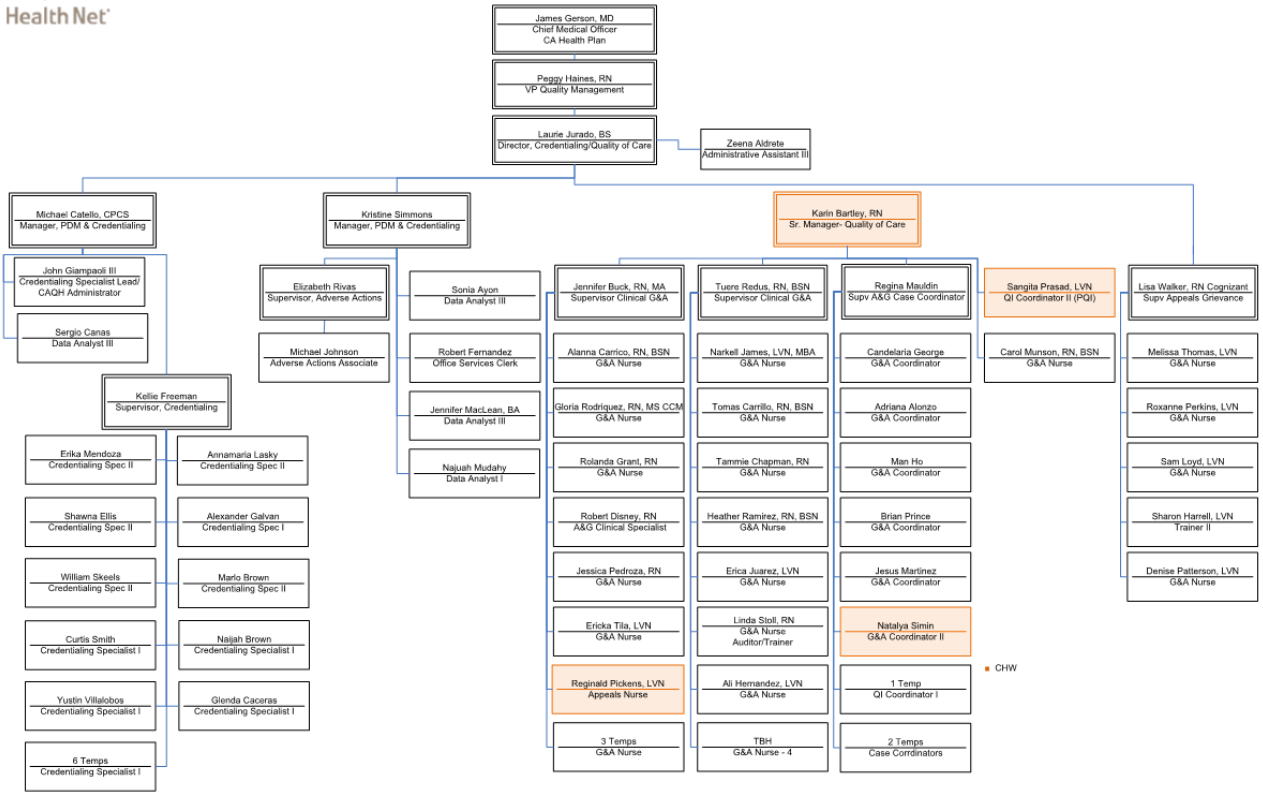
These organizational charts represent the complete departments and not the SNP line of business only.

February 2018

Member Appeals & Grievances



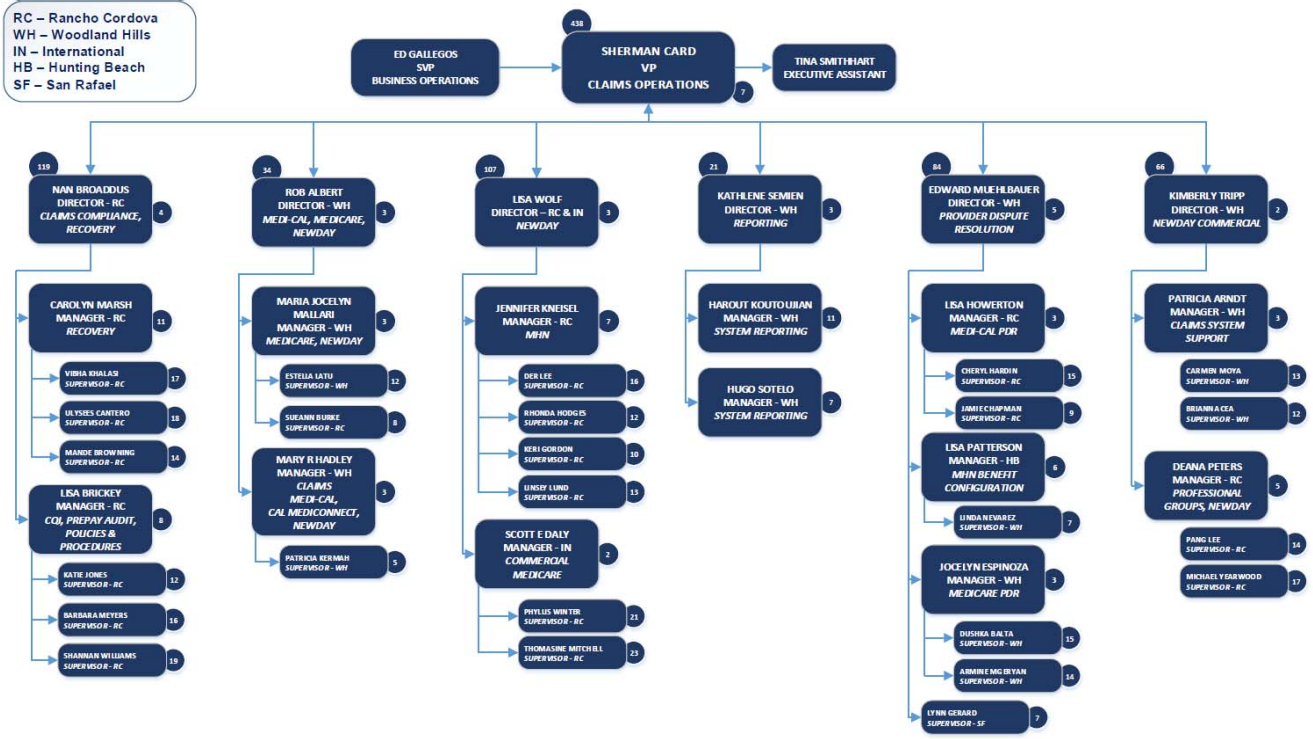
Credentialing/Clinical Appeals/PQI



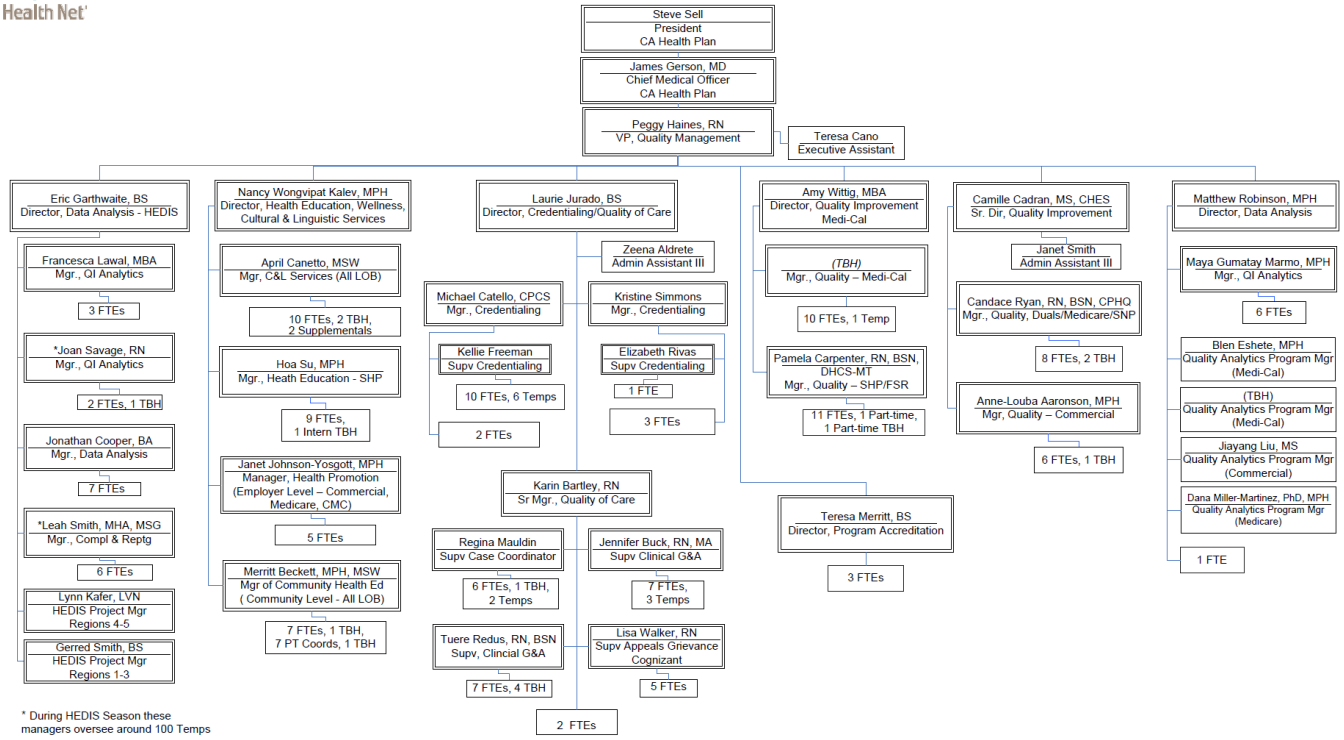
Health Net

CLAIMS OPERATIONS

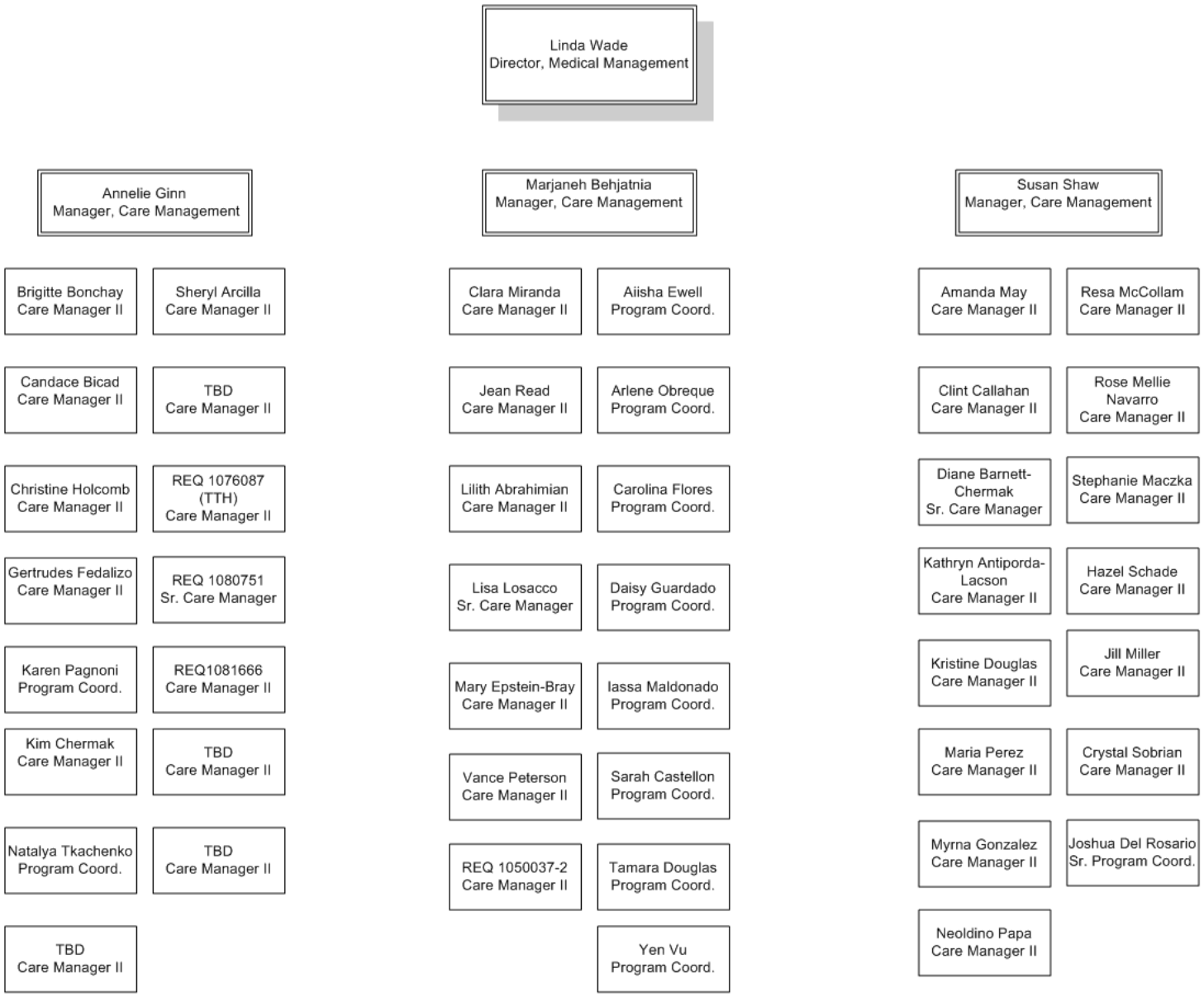
RC – Rancho Cordova
WH – Woodland Hills
IN – International
HB – Hunting Beach
SF – San Rafael



Quality Management

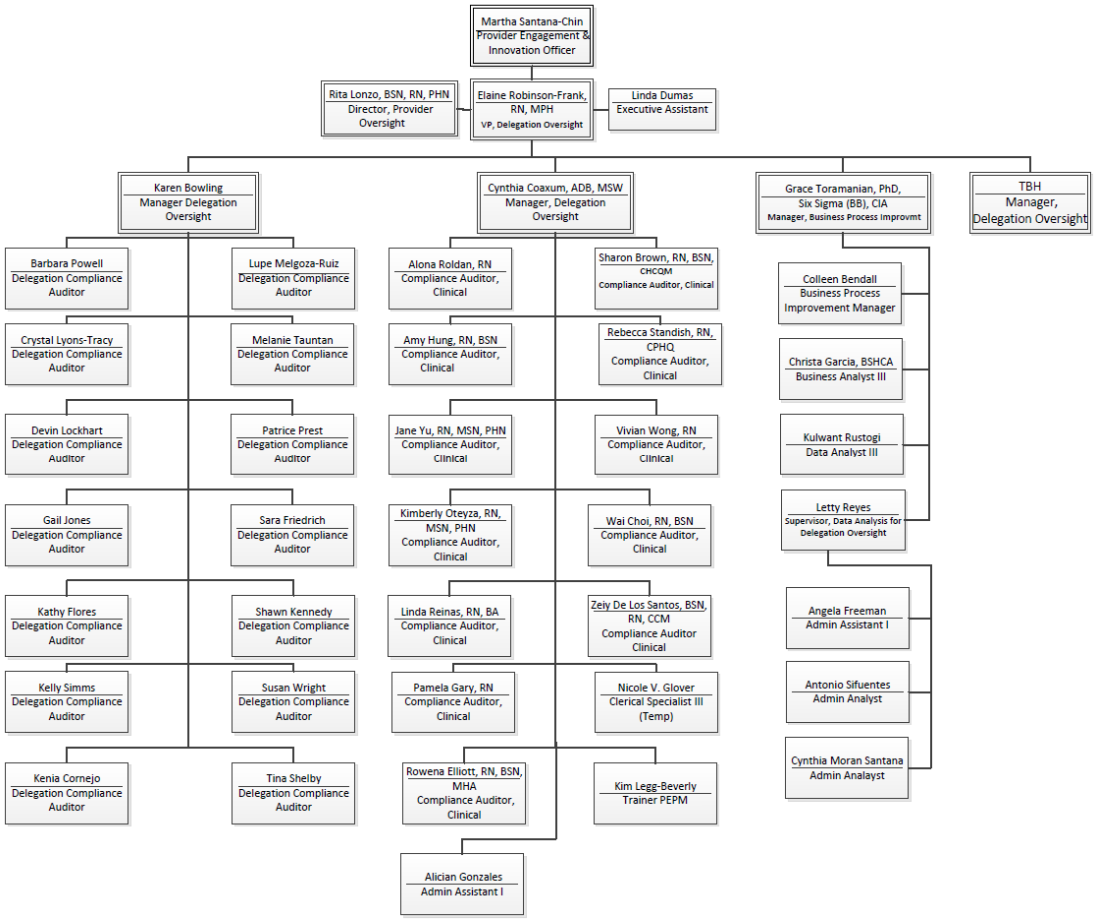


SPEACIAL NEEDS PROGRAM (SNP) CASE MANAGEMENT

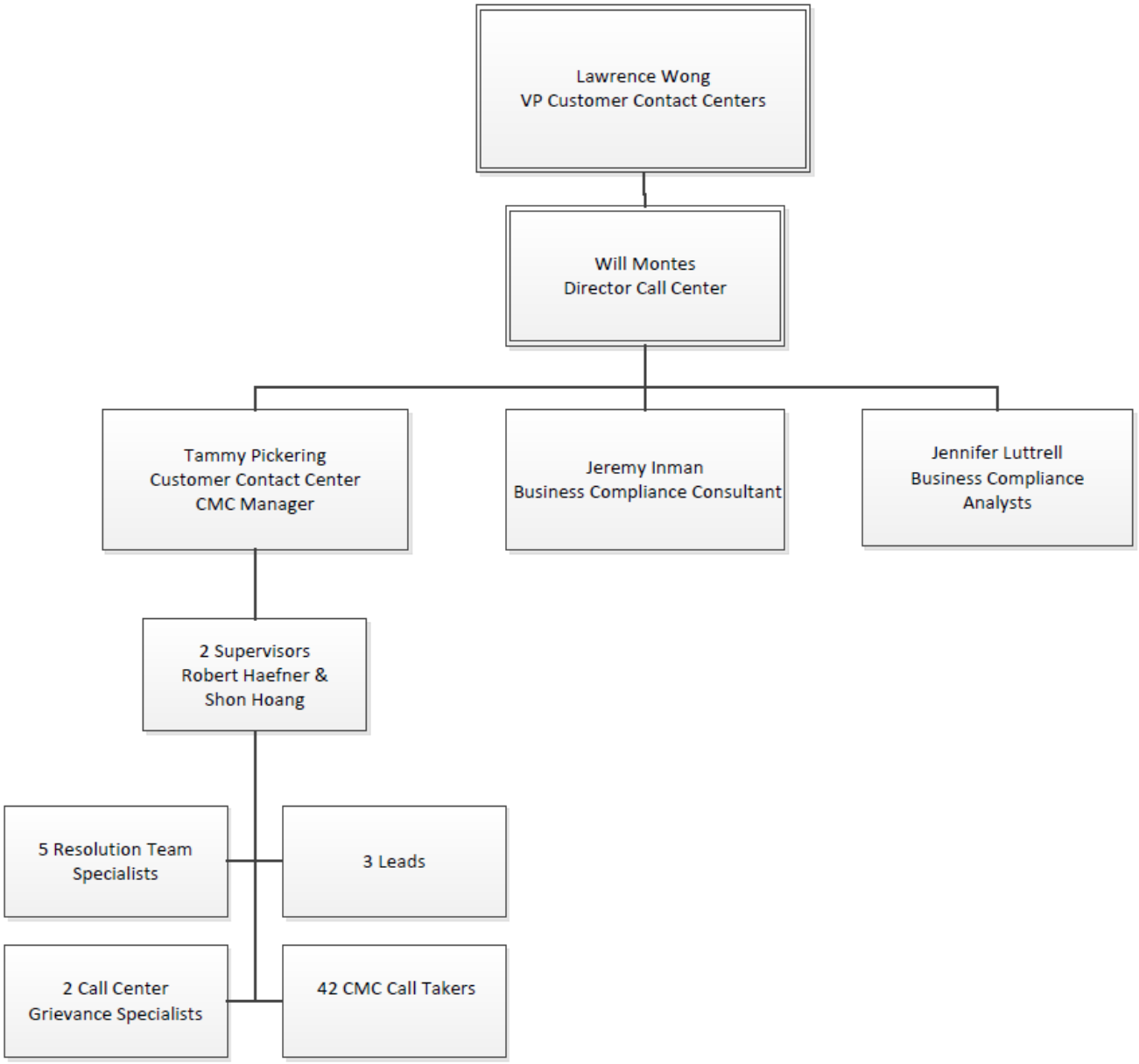


Health Net

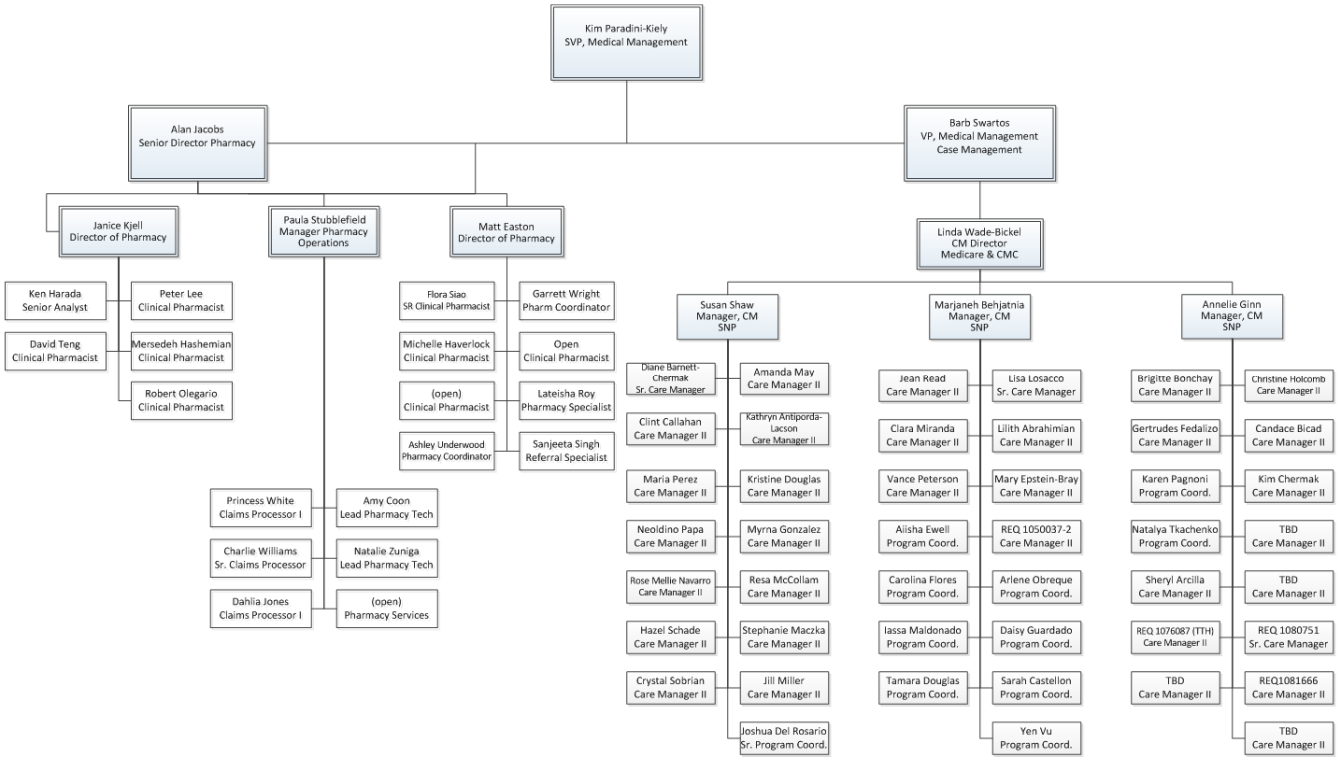
Delegation Oversight



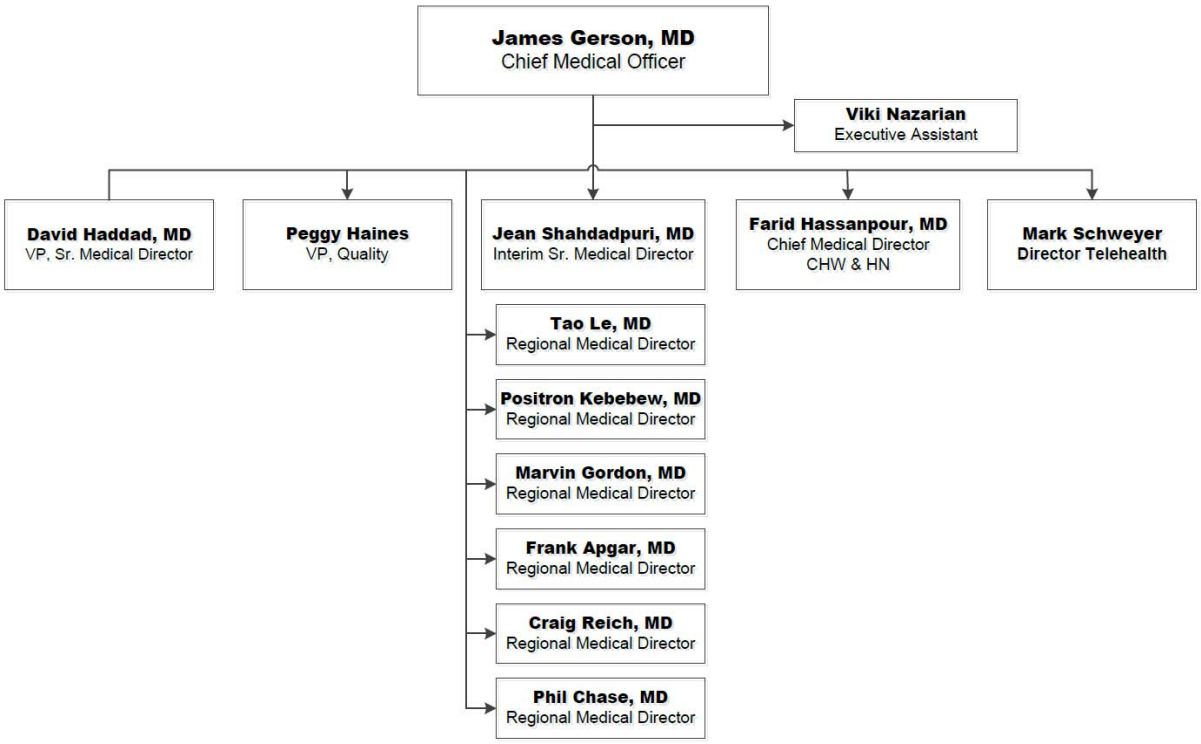
Customer Call Center Oversight 2018

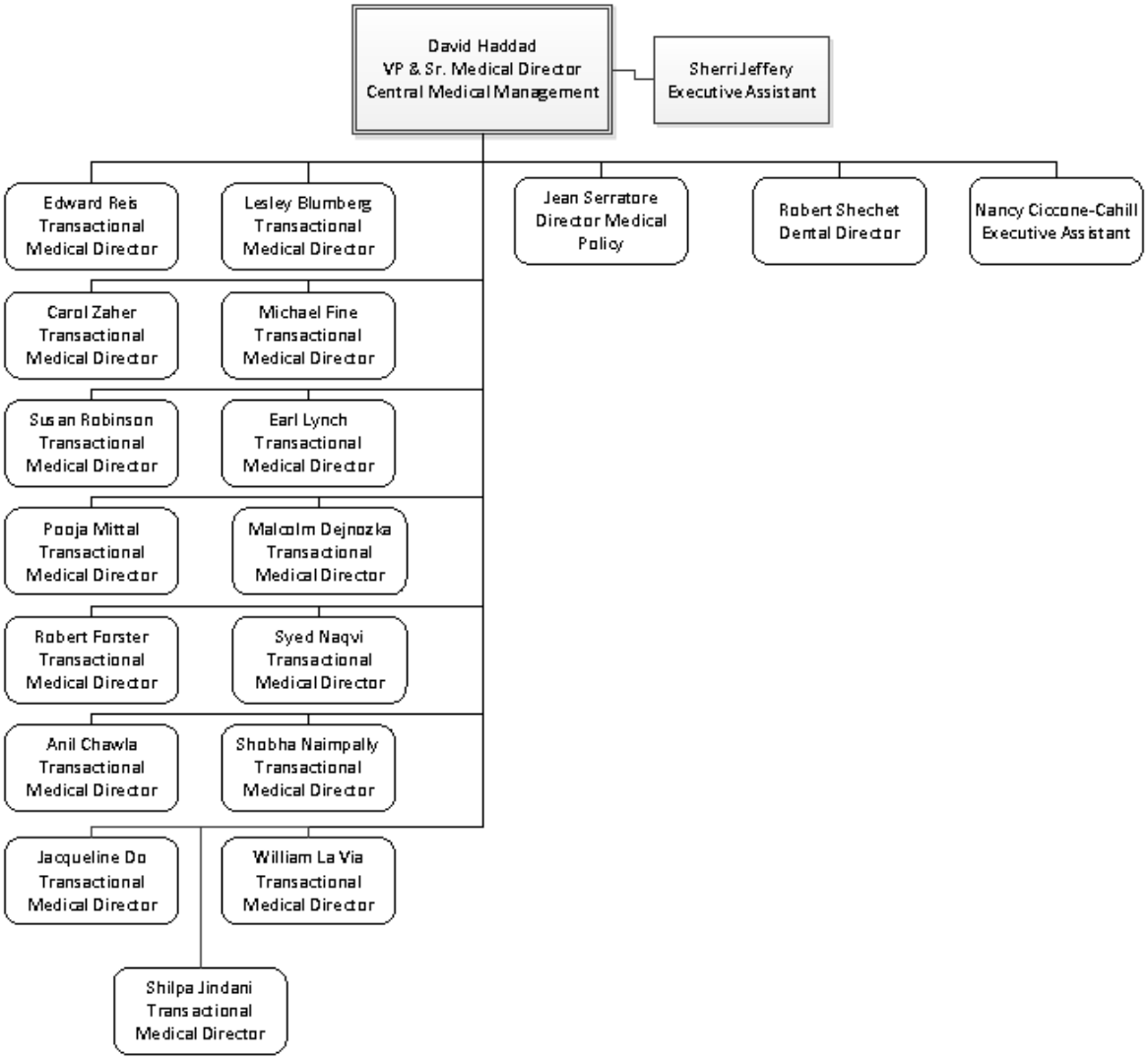


Medical Management

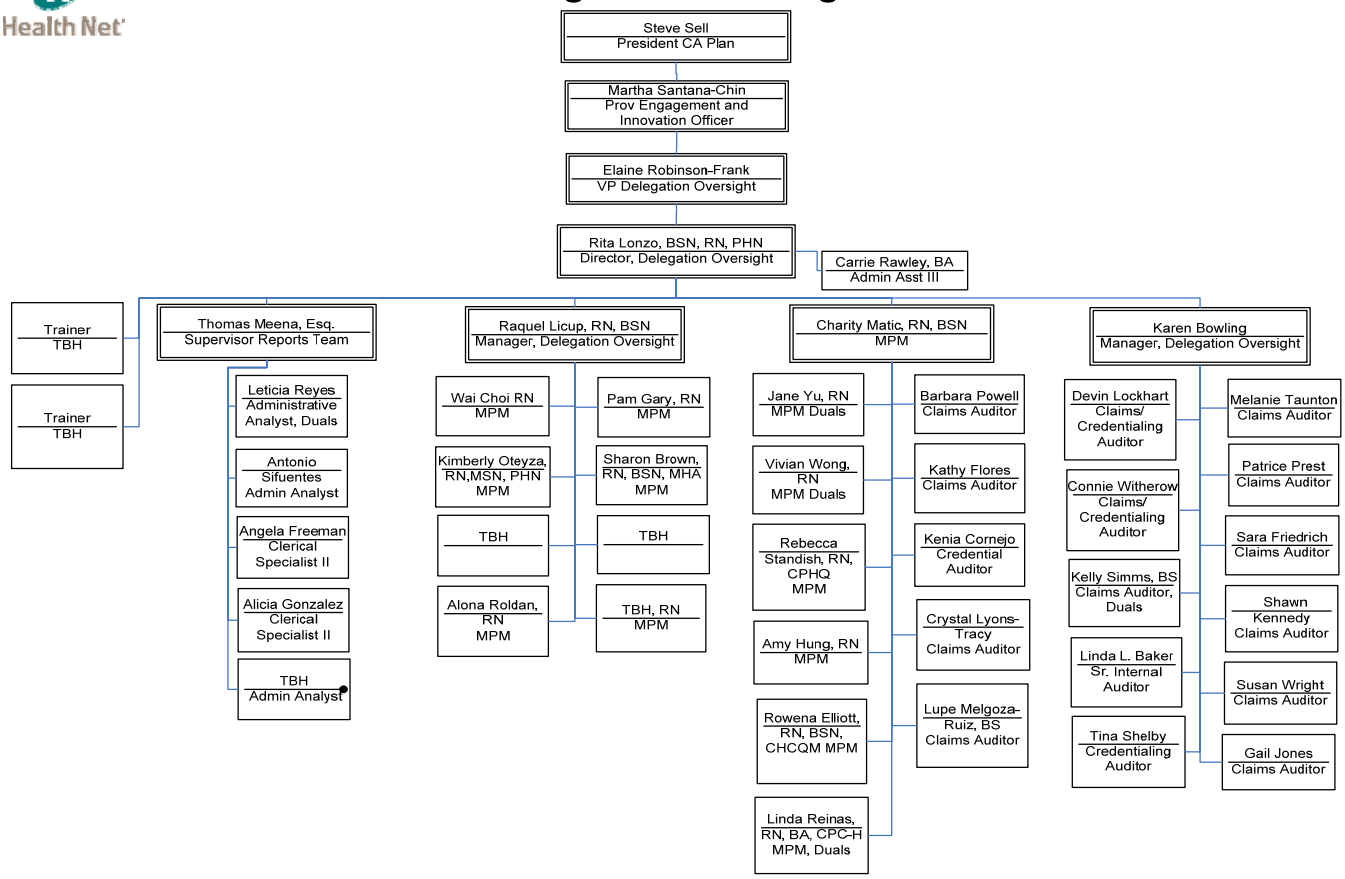


Medical Management Medical Directors



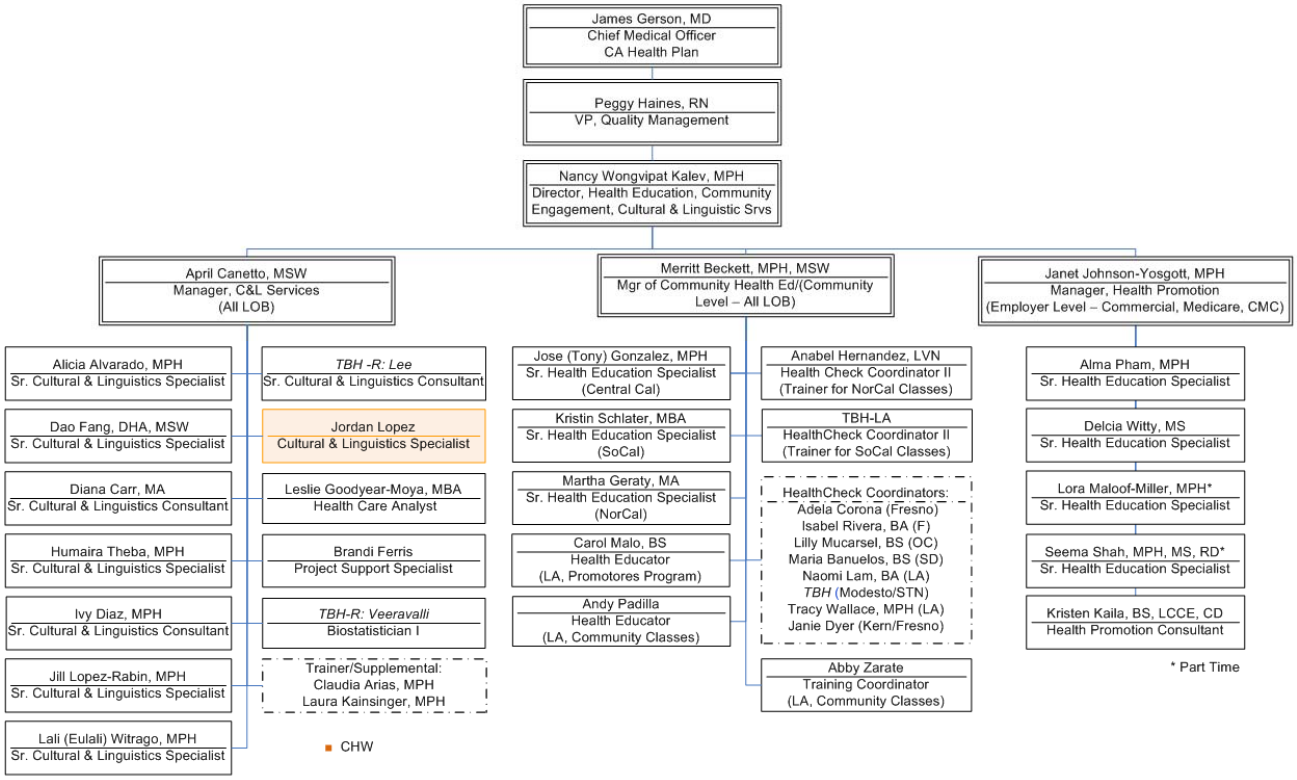

David Haddad
VP & Sr. Medical Director
Central Medical Management
Sherri Jeffery
Executive Assistant
Edward Reis
Transactional
Medical Director
Lesley Blumberg
Transactional
Medical Director
Jean Serratore
Director Medical
Policy
Robert Shechet
Dental Director
Nancy Ciccone-Cahill
Executive Assistant
Carol Zaher
Transactional
Medical Director
Michael Fine
Transactional
Medical Director
Susan Robinson
Transactional
Medical Director
Earl Lynch
Transactional
Medical Director
Pooja Mittal
Transactional
Medical Director
Malcolm Dejnozka
Transactional
Medical Director
Robert Forster
Transactional
Medical Director
Syed Naqvi
Transactional
Medical Director
Anil Chawla
Transactional
Medical Director
Shobha Naimpally
Transactional
Medical Director
Jacqueline Do
Transactional
Medical Director
William La Via
Transactional
Medical Director
Shilpa Jindani
Transactional
Medical Director

Delegation Oversight



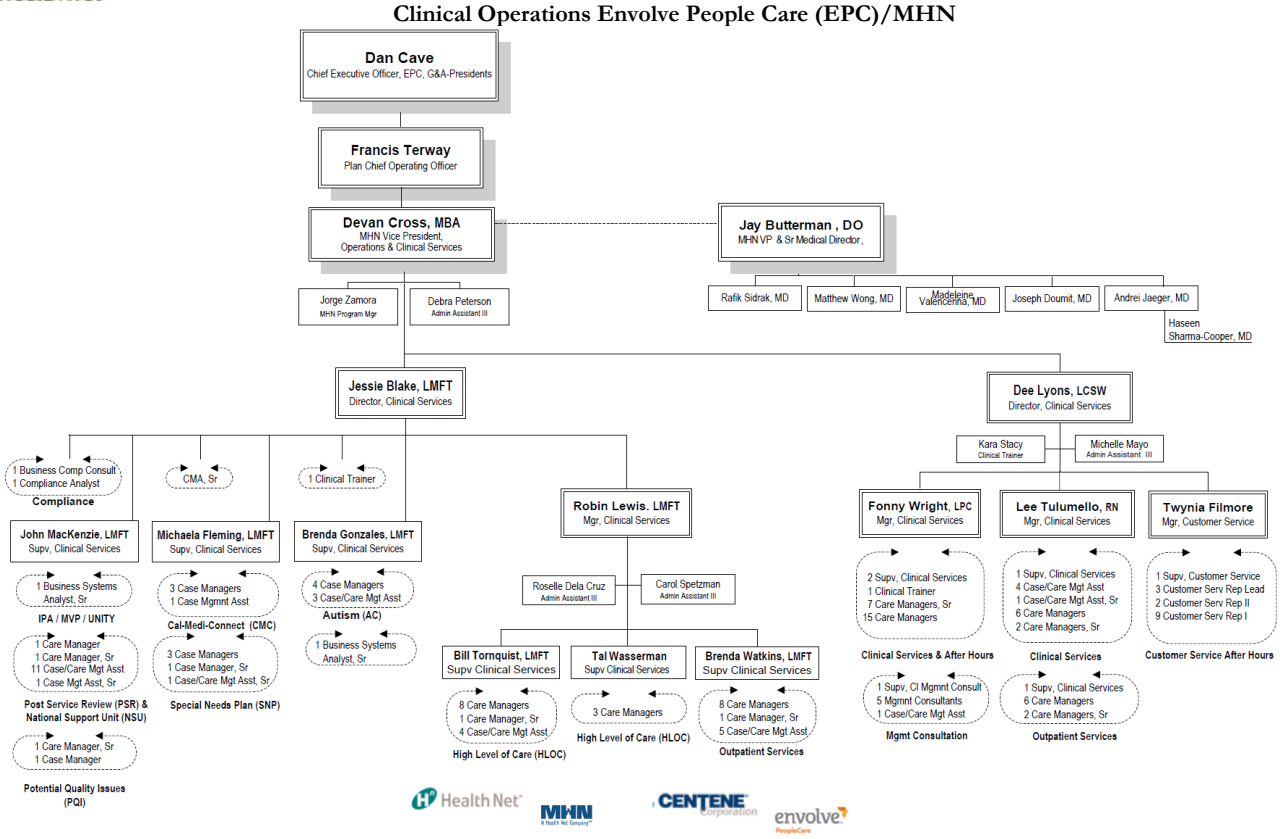
Health Net

Cultural & Linguistic Services and Wellness Oversight



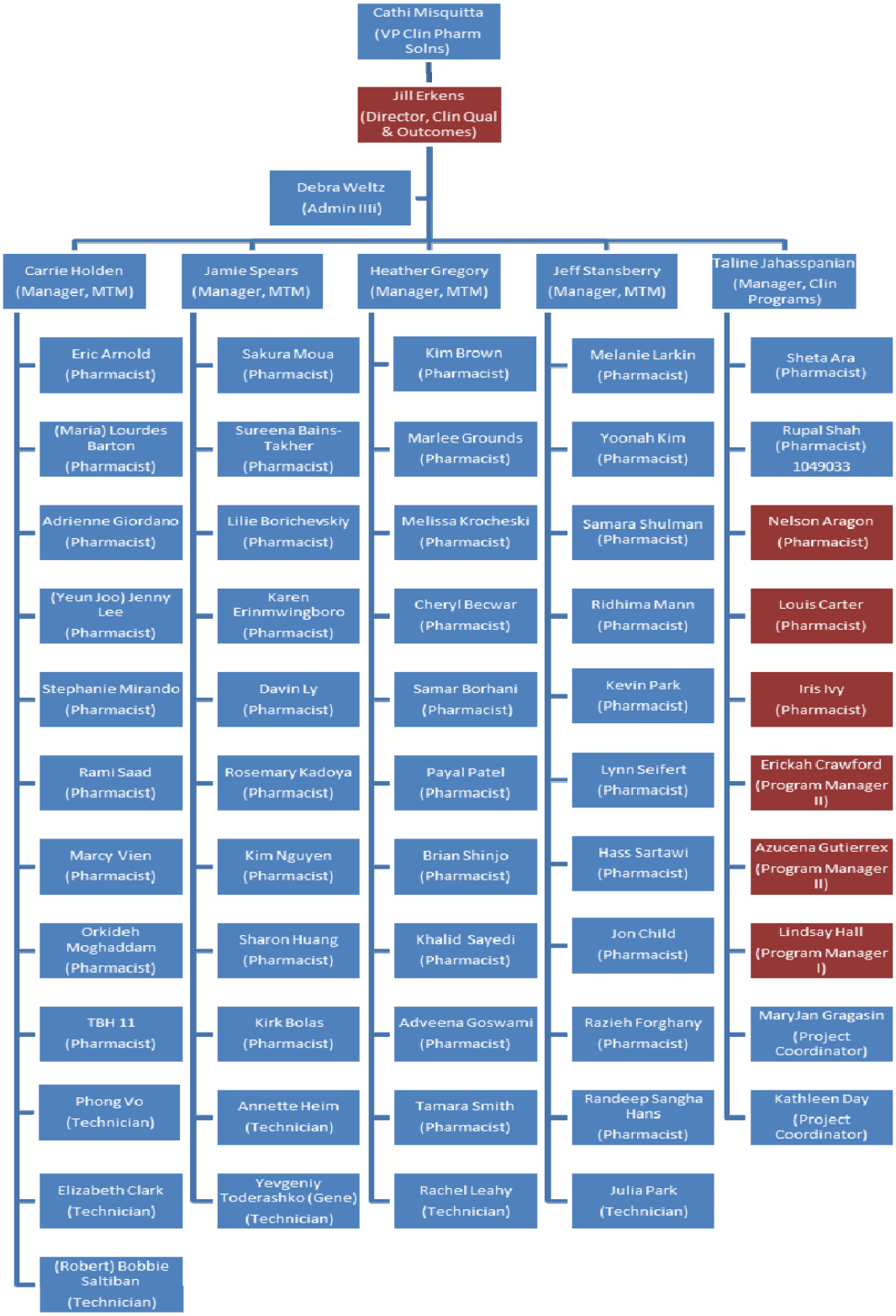
Health Net

Clinical Operations Envolve People Care (EPC)/MHN



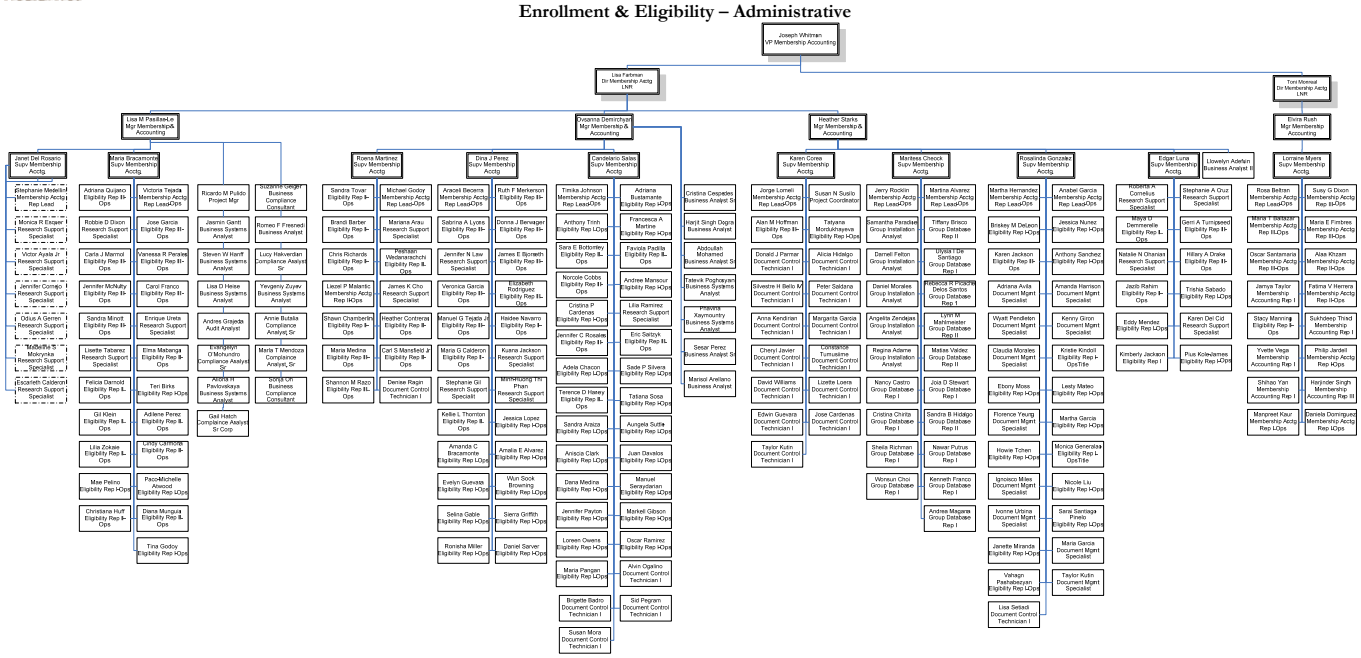
Health Net

Pharmacy Operations Oversight and Clinical



Health Net

Enrollment & Eligibility – Administrative



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wellcare By health net

Akorbi
PEOPLE ■ TECHNOLOGY ■ LANGUAGE

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

Lao (ພາສາລາວ)
ທ່ານເວົ້າພາສາບໍ? ພວກເຮົາຈະຈັດກຽມນາຍແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Mandarin (中文)
您講中文嗎? 我們將免費為您提供翻譯。

Mixteco
¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

Navajo (Diné bizaad)
Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

Portuguese (Português)
Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

Punjabi (ਪੰਜਾਬੀ)
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

Russian (Русский)
Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

Spanish (Español)
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

Tagalog
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

Thai (ภาษาไทย)
คุณพูดภาษาไทยใช่หรือไม่
เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

Vietnamese (Tiếng Việt)
Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

American Sign Language (ASL)

Please call Provider Services using the number on the member's ID card or contact 800-929-9224.

For office use only. Do NOT post in a patient area.

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MEDI-CAL LINKAGE / ENROLLMENT
TRACKING LOG FOR INITIAL HEALTH APPOINTMENT

Initials	Patient Name	ID Number	Enrollment / Linkage Date	Phone Number	Date of First Contact	P L	Date of Second Contact.	P L	Date of Third Contact	P L	Appointment Date / Status	K N

Instructions: O Record results of actions taken for scheduling Initial Health Appointment within 120 days of enrollment.

- *Legend* P = Phone L = Letter K = Kept Appointment N = No Show

ADULT HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. _____

Age: _____ Sex: Male Female MR# _____

Immunizations current: Yes No
(See Immunization list below)

TB Risk: Yes No
(Every Periodic Physical Examination)

Advanced Directive discussed: Yes No

Date Discussed: _____

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	18 yrs. and older	Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.			
IHEBA/"Staying Healthy"	18 yrs and Older	Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years.	Record on Staying Healthy Form.		
Check-Up Visit	18 yrs. and older	Every 1-3 years			
	Age > 65	Annually			
Cholesterol	Male, 35 yrs. and older	Every 5 years			
	Female, 45 yrs. and older	Every 5 years			
Diabetes Mellitus Screening	As risk factors indicate	PRN			
Urinalysis	65 yrs. and older	PRN			
Breast Exam	Age > 40 yrs.	Annually			
Mammography	50-74 yrs.	Every 2 years			
Pelvic Exam	19-39 yrs.	Every 1-3 yrs.			
	40 and older	Annually			
Pap Smear	Onset of sexual activity or 21-65 yrs.	Every 1 to 3 yrs. At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.			
Chlamydia	< age 25, all sexually active non-pregnant women > age 25, as risk factors indicate				
Bone Density	65 yrs. and older	At least once			
Vitamin D Deficiency	65 yrs. and older	At clinician's discretion			
TSH Screening	40 yrs. and older	Every 5 years			
Fecal Occult Blood	50-75 yrs., then at clinician's discretion	Annually			
Sigmoidoscopy	50 and older	3-5 yrs.			
	High Risk	PRN			
Colonoscopy	50 and older	Every 10 years			
Prostate Exam	Physician discretion and as clinically indicated	PRN			
PSA	50 and older or as clinically indicated	PRN			
Adult Immunizations					
Tetanus-Diptheria-Pertussis(Tdap) Tetanus-Diphtheria (Td)	18 yrs. and older 18 yrs. and older	1 dose only Every 10 yrs.			
HPV	Females, 18-26 yrs. (HPV2 or HPV4) Males, 18-26 yrs (HPV 4)	3 doses			
Varicella	18 yrs. and older	2 doses if no evidence of immunity			
Zoster	60 yrs. and older	1 dose			
MMR	Born 1957 or after Born before 1957	1-2 doses unless immunity documented Considered immune, unless documentation of immunity required			
Influenza	18 yrs. and older	Annually			
Pneumococcal	18 yrs. and older	1-2 doses, when clinically indicated			
Hepatitis A	18 yrs. and older	2 doses			
Hepatitis B	18 yrs. and older	3 doses			
Meningococcal	18 yrs. and older	1 dose, 2nd dose if high risk			

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
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Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

LAST NAME: **FIRST NAME:** **MRN#**

PLACE OF SCREENING: **CIRCLE ONE:** ANSI - #____ ISO - #____

AUDIOMETER: **SCORING:** Child responds at 25 dB: Child does not respond at 25 dB: ☐

DATE OF LAST CALIBRATION: **AGE:**

		1000	2000	3000	4000
1st Screen Date:_____	RIGHT Ear				
2nd Screen Date:_____					

		1000	2000	3000	4000
	LEFT Ear				

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

		1000	2000	3000	4000
1st Screen Date:_____	RIGHT Ear				
2nd Screen Date:_____					

		1000	2000	3000	4000
	LEFT Ear				

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

		1000	2000	3000	4000
1st Screen Date:_____	RIGHT Ear				
2nd Screen Date:_____					

		1000	2000	3000	4000
	LEFT Ear				

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To:

Signature & Title of Person Performing Test

HISTORIA MEDICA Y EXAMEN FISICO

MRN # _____

NOMBRE:	ESTADO CIVIL: ❑· S ❑ C ❑ V ❑ D ❑ SEP.	FECHA:
FECHA DE NACIMIENTO:	TEL (CASA):	TEL (TRABAJO):
OCUPACION/EMPLEADOR	Nº del Seg. Soc.:	Nº del SEGURO:

HISTORIA MEDICA FAMILIAR

SI ALGUN PARIENTE SANGUINEO HA TENIDO CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES, PONGA UN CIRCULO ALREDEDOR DEL NUMERO E INDIQUE QUE PARIENTE.

1) ALCOHOLISMO
2) ANEMIA
3) ASMA
4) ARTRITIS
5) SANGRA FACILMENTE
6) CANCER
7) DIABETES
8) EPILEPSIA
9) GLAUCOMA
10) ASMA DEL HENO
11) ENFERMEDAD CARDIACA
12) HIPERTENSION
13) ENFERMEDAD RENAL
14) ENFERMEDAD MENTAL
15) MIGRAÑA
16) OSTEOPOROSIS
17) APOPLEJIA
18) TIROIDES
19)
20)

INTERNACIONES EN HOSPITALES

(sin incluir embarazos)

AÑO — ENFERMEDAD U OPERACION

ALERGIAS

Pasado:

Presente:

ANOTE TODOS LOS MEDICAMENTOS QUE TOMA AHORA: (incluso los que se venden sin receta médica)

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

VACUNA (Fecha de la última)	PRUEBA / EXAMEN (Fecha del último)
Tétano / Difteria	Colesterol
Influenza	Dental
Neumocócica	Vista
Hepatitis	Oído
	Rectal / Excremento
	Sigmoidoscopía
	Prueba cutánea de tuberculosis

HISTORIA MEDICA

Marque con una palomita (✓) e indique la edad en la que tuvo cualquiera de los siguientes síntomas o enfermedades. MARQUE con una equis (X) los problemas actuales.

PROBLEMAS PRINCIPALES 1) _____ 2) _____ 3) _____

❑ Oído disminuido
❑ Zumbido en el oído
❑ Infecciones de oído - *frecuentes*
❑ Mareos
❑ Falla de la vista ❑ Dolor del ojo
❑ Visión doble o borrosa
❑ Infecciones del ojo - *frecuentes*
❑ Sangrado de la nariz - *recurrentes*
❑ Problema del seno
❑ Dolores de garganta - *frecuentes*
❑ Asma del heno / Alergias
❑ Ronquera - *prolongada*
❑ Neumonía / Pleuresía
❑ Bronquitis / Tos crónica
❑ Asma / Jadeo
Falta de aliento:
❑ Haciendo esfuerzo
❑ Estando acostado
❑ Dolor del pecho
❑ Presión sanguínea alta
❑ Soplo cardíaco
❑ Pulso irregular
❑ Palpitaciones
❑ Tobillos hinchados
❑ Desmayos
❑ Dolor de pierna - *caminando*
❑ Venas varicosas / Flebitis
❑ Pérdida del apetito - *reciente*
❑ Dificultad para tragar

❑ Indigestión o acidez estomacal
❑ Ulceras pépticas
❑ Dolor abdominal - *crónico*
❑ Problema de vesícula biliar
❑ Ictericia / Hepatitis
❑ Cambio de hábitos de evacuación intestinal
❑ Diarrea ❑ Estreñimiento
❑ Diverticulosis
❑ Enfermedad de Crohn / Colitis
❑ Excrementos sanguinolentos o alquitranados
❑ Hemorroides
❑ Hernia
❑ Infecciones urinarias - frecuentes
❑ Sangre en la orina
❑ Emisión de orina ❑ Durante la noche más de dos veces
❑ Dolorosa
❑ Pérdida del control
❑ Disminución de la Fuerza/Flujo
❑ Cálculos renales
❑ Enfermedad venérea
❑ Derrame uretral
❑ Fatiga crónica
❑ Pérdida de peso - *reciente*
❑ Anemia
❑ Se magulla fácilmente

❑ Cancer
❑ Diabetes
❑ Enfermedad de tiroides
❑ Convulsiones / Ataques epilépticos
❑ Apoplejía
❑ Temblor / Manos temblantes
❑ Debilidad muscular
❑ Adormecimiento / Sensaciones de hormigueo
❑ Dolores de cabeza - *frecuentes*
❑ Artritis / Reumatismo
❑ Dolor de Espalda - *recurrente*
❑ Fracturas óseas / Lesión de articulaciones
❑ Gota
❑ Osteoporosis
❑ Dolor de pie
❑ Pies fríos y adormecidos
❑ Sarpullido
❑ Ronchas
❑ Psoriasis
❑ Eczema
❑ Sueño - *dificultad*
❑ Nerviosismo
❑ Depresión
❑ Pérdida de la memoria
❑ Mal humor - *excesivo*
❑ Fobias

❑ Enfermedad mental
❑ Varicela
❑ Poliomielitis
❑ Paperas
❑ Sarampión
❑ Rubéola
❑ Fiebre reumática
❑ Escarlatina
❑ Tuberculosis
❑ Herpes
❑ Contacto con sangre o fluidos corporales
❑ Alcohol _____ onzas por semana
❑ Fuma _____ cig. por día
Número de años_____
❑ Café / Té
Nº de tazas por día _____
❑ Directivas con adelanto

HOMBRES - Favor de completar
Fecha del último examen de próstata

❑ Normal ❑ Anormal
Fecha de la última PSA _____

MUJERES - Favor de completar
Flujo Menstrual:
❑ Reg. ❑ Irreg.
❑ Dolor / Cólico
Días de flujo _____
Duraciones del ciclo _____
Fecha del último período _____
❑ Dolor / Sangramiento durante o después del coito
Número de:
Embarazos _____
Abortos provocados _____
Abortos espontáneos _____
Nacimientos con vida _____
Método de control de la natalidad _____
Píldora de control de la natalidad (nombre) _____
❑ Calores súbitos / Menopausia
Fecha del último examen pélvico _____
Fecha de la última prueba de Papanicolaou _____
❑ Normal ❑ Anormal

Fecha del último examen de senos _____
Fecha del último mamograma ____
❑ Normal ❑ Anormal

SINOPSIS **PARA USO DE OFICINA SOLAMENTE:**

Directivas Anticipadas: ❑ Si ❑ No Educativo de Directivas Anticipadas: ❑ Cuestionario "Mantengase Saludable" Fecha:_____

Firma: Dr./Dra.

MEDICATION AND SUMMARY CHART MRN

NAME: **DATE OF BIRTH:** **HT:** **WT:**

ALLERGIES

Pharmacy Name & Telephone #

Patient's (home) Telephone #s: (work)

PROBLEM # START DATE	MEDICATION DOSAGE/FREQ.	REFILL DATES *(record any changes in dosage or frequency)*				STOP DATE OR CONTINUED

CHRONIC PROBLEM LIST

	Date Resolved
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Signature Page

(Please post on left-hand side of each Medical Record)

Please Write Signature as Entries are Typically Signed	Print Name in Full (First Name, Last Name, Title)

Medical / Behavioral CoManagement Referral Form

Date of Referral: E-Mail:	Referred by: Referrer's phone #:	
Patient Name: Patient Contact Information: Patient Expecting MHN's Call: Special Instructions:	Patient ID #:	DOB:
Current Provider / Primary Care Physician / Specialist Name: Telephone #: Office Contact Name:	Fax #: Telephone #:	
If Inpatient, complete the following: Service Requested: Facility Name: Facility Contact Name:	Diagnosis: Facility City/State: Telephone #:	

Requesting:

- Outbound call to member
- Outbound call to provider/facility
- Psych consult on med bed/nursing home/SNF
- Consultation with Referring Case Manager
- Other / Unknown

Referral to MHN (Behavioral Health Triggers)

- Eating Disorder admitted to medical unit
- Catastrophic Illness requiring behavioral health support
- Behavioral health follow-up upon discharge from medical admission
- Complicated detox requiring medical admission
- Difficult placement due to behavioral health problems
- Medical admission with planned or actual transfer to psychiatric unit
- Referrals for post discharge substance abuse treatment while still at medical facility
- Pain management with substance abuse issues
- Frequent ER visits for behavioral health diagnoses or medical reason impacted by behavioral health issues
- Dementia with acute exacerbation of behavioral / psychological symptoms
- Autism Spectrum Disorders with behavioral health needs
- Member screened positive on depression screening
- Other

MHN referral to Health Net (Medical Triggers)

- Lack of an established or an ineffective treatment plan
- Over/under/inappropriate utilization of services
- Discharged/discharging from behavioral inpatient with medical needs
- Medical condition needing follow-up
- Lack of education of disease course/process
- Non-adherence to treatment/medications, missed appointments
- Compromised patient safety
- Lack of family/social support
- Lack of financial resources to meet health needs
- Exhaustion of medical benefits
- Member requesting medical Case Manager
- Autism Spectrum Disorders (OT, PT, ST requests)
- Pharmacological question
- Other

Additional Information:

Contact Information for Referrals to MHN

- Email completed form to MHN at: MHN.Case.Management.Referrals@healthnet.com
  OR
- For HNCA members, fax completed form to MHN at (855) 703-3268
- For HNAZ & HNOR/WA members, fax completed form to MHN at (855) 661-0077
- Urgent/Emergent requests, also call (888) 426-0030

Contact Information for MHN Referrals to Health Net

For Health Net / MHN Use Only

- Email completed form to Case Management Referrals/GRP/HNCA/HNT
- Urgent/Emergent Requests, also call (888) 732-2730

Created by Sandra Morrison
Manager, Healthnet Care Management 12/2013
Rev 01/28/14 by L. Tulumello/T. Wasserman

Medicare and Medicare-Medicaid Plans
Prescription Claim Form

You can use this form to ask us to pay for our share of your covered drugs. Check your Evidence of Coverage or Member Handbook for more information.

❑ If you wish to have a person complete this form on your behalf, please check this box and return a completed *Appointment of Representative* form (page 2) along with the prescription claim form.

INSTRUCTIONS:
1. Complete this form. 2. Staple pharmacy receipt(s) to the form (we can't accept cash register receipts) and mail to:
Medicare Part D Pharmacy Claims PO Box 419069 Rancho Cordova, CA 95741-9069

MEMBER INFORMATION:				
Member ID #:			Group #:	
Last name :	First name :	MI:	Phone #:	
Address:	City:		State:	ZIP code:
Gender: ❑ Male ❑ Female	Date of birth: _____/_____/ _____			
Has your claim been processed with another insurance carrier? ❑ No ❑ Yes If yes, attach a copy of your Explanation of Benefits (EOB) or a statement from your other insurance to your pharmacy receipt(s).				
Name of other insurance company:	Other insurance policy number:			
Name of other insurance policyholder:	Name of policyholder's employer:			
Other insurance type: ❑ Single ❑ Family				
Other comments: _____ _____ _____ _____				
I certify that the above information is correct. X_____ ____/_____/ _____ Member's Signature Date				

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual,_____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I,_____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee **must** be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

SPC_RPT_BRM_30 HEALTH NET SENIORITY-PLUS CAPITATION
03/27/15
ACTIVITY ANALYSIS REPORT FOR THE MONTH
04/15 Page: 1
By SITE
Provider ID: 999 Provider: MNNNNNNN HOSPITAL NNN
Phone Number: (999) 999-9999
Address: 99999 SAMPLE BLVD
STE 999
UNKNOWN, CA 99999-9999

Member						A		Member																	Risk*
- - - - - - - M E M B E R S					I N F O - - - - - - -			Group	Pl	Sat															
		PIP	SCC		Prod	G	Birth		Eff Date																	
Last, First Name	MI	Sex	Member ID		HIC CODE			ID#	Code	Prvd Phy		1	2	3	4	5	6	7	8	DCG		E	Date	Can Date	
CIN#			Aid Cod	Pro Cod	MCR-STAT A	B	D	Aid Cat																	
XXXXX, YYYYYY	Z		X		X99999999		999999999X		99XXX9	XX9	999	999999		X	X	9	X	X	X	X	X	99999		XXX	XX01/01/XX	01/01/XX

Change Desc: Provider Rules Change Eff: 01/XX
PH: 999 9999999

XXXXX, YYY	Z		X		X99999999		999999999X		99XXX9	XX9	999	999999		X	X	9	X	X	X	X	X	99999		XXX	XX01/01/XX	01/01/XX

Change Desc: Provider Rules Change Eff: 01/XX
PH: 999 99999999

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*Member Risk Data: 1 = Part A Stat, [Values: Y = Part A, N = Part A Equivalent]
2 = Medicaid Stat, [Values: Y/N]
3 = Member Status, [Values: 0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized]
4 = Working Aged, 5 = Medicaid Add-on, 6 = Default Risk Factor, 7 = Disabled [Values: Y/N]
8 = Dialysis_Ind [Values : Y/N]

SPC_RPT_BRM_30 HEALTH NET SENIORITY-PLUS CAPITATION
03/27/15
ACTIVITY ANALYSIS REPORT FOR THE MONTH
04/15 Page: 2
By SITE
Provider ID: 999 Provider: MNNNNNNNN HOSPITAL NNN
Phone Number: (999) 999-9999
Address: 99999 SAMPLE BLVD STE
999
UNKNOWN, CA 99999-9999

Member						A		Member																	Risk*
- - - - - - - M E M B E R S					I N F O - - - - - - -			Group	Pl	Sat															
		PIP	SCC		Prod	G	Birth		Eff Date																	
Last, First Name	MI	Sex	Member ID		HIC CODE			ID#	Code	Prvd Phy		1	2	3	4	5	6	7	8	DCG		E	Date	Can Date	
CIN#			Aid Cod	Pro Cod	MCR-STAT A	B	D	Aid Cat																	
XXXXX, YYYYY	Z		X		R99999999		999999999X		99XXX9	XX9	999	999999		X	X	9	X	X	X	X	X	99999		XXX	XX01/01/XX	01/01/XX

Change Desc: Provider Rules Change Eff: 01/XX
PH: 999 9999999
XXXXXX, YYYYY Z X R99999999 999999999X 99XXX9 XX9 999 999999 X X 9 X X X X X 99999 XXX XX01/01/XX 01/01/XX

Change Desc: Provider Rules Change Eff: 01/XX
PH: 999 9999999

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*Member Risk Data: 1 = Part A Stat, [Values: Y = Part A, N = Part A Equivalent]
2 = Medicaid Stat, [Values: Y/N]
3 = Member Status, [Values: 0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized]
4 = Working Aged, 5 = Medicaid Add-on, 6 = Default Risk Factor, 7 = Disabled [Values: Y/N]
8 = Dialysis_Ind [Values : Y/N]

SPC_RPT_BRM_30 HEALTH NET SENIORITY-PLUS CAPITATION
03/27/15
ACTIVITY ANALYSIS REPORT FOR THE MONTH
04/15 Page: 275
By SITE

Provider ID: 999 Provider: MNNNNNNN HOSPITAL NNN
Phone Number: (999) 999-9999 Address: 99999 SAMPLE BLVD STE 999
UNKNOWN, CA 99999-9999

Member A Member
- - - - - - - M E M B E R S I N F O - - - - - - - Group Pl Sat Risk*
PIP SCC Prod G Birth Eff Date
Last, First Name MI Sex Member ID HIC CODE ID# Code Prvd Phy 1 2 3 4 5 6 7 8 DCG
E Date Can Date
CIN# Aid Pro MCR-STAT Aid
Cod Cod A B D Cat

** Site Total **

Activity Description		Number of Members
ADDS:	Add Contract	99
	Reinstate Contract	99
	Hosp/Prov Transfer In	99
	** Total Adds:	999
CANCELS:	Cancel Contract	99
	Hosp/Prov Transfer Out	99
	** Total Cancels:	99
OTHER CHANGES:	Change Address	99
	Change County Code	99
	Change Members' OED	9
	Change Members' DOB	9
	Change Members' Name	9
	Group Transfers	99
	Status Changes	999
	Age Changes	99
	Prv Rules Change	9,999
	Group Rates Change	9
	CMS Rate Change	99
	Prv Eff Date Change	9
	Phys transfer in	99
	Phys transfer out	99
	Phys Eff Date Change	9
	Cin num Change	9

Prj cod Change	9
Aid cod Change	9
Aid cat Change	9
Med stat A Change	9
Med stat B Change	9
Med stat D Change	9
** Total Misc Changes:	9,999
NET MEMBERSHIP CHANGES (Total ADDS - Total CANCELS):	99

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*Member Risk Data: 1 = Part A Stat, [Values: Y = Part A, N = Part A Equivalent]
2 = Medicaid Stat, [Values: Y/N]
3 = Member Status, [Values: 0 = Standard, 1 = ESRD, 2 = Hospice, 3 = Institutionalized]
4 = Working Aged, 5 = Medicaid Add-on, 6 = Default Risk Factor, 7 = Disabled [Values: Y/N]
8 = Dialysis_Ind [Values : Y/N]

[*HEALTH PLAN OR PROVIDER ORGANIZATION LETTERHEAD*]
(Use 12-Point Font)
Medicare Advantage
INFORMATIONAL LETTER TO PATIENT AND/OR PROVIDER/PHYSICIAN
(*Issue for carve-out situations when group is referring Patient and/or physician to another entity or source for requested services that the group does not have responsibility for providing or authorizing*)

[*Date*]

[*Name of Patient or Representative*]
[*Address*]

Patient Name:
Patient ID#:
Health Plan Name:
Attending Physician's Name:
Requested Service:

Dear [*Patient Name*]:

This is **NOT** a denial of service. This notice is to inform you that [*insert provider organization name*], under contract with [*insert Health Plan name*], is not responsible for providing or authorizing the above requested service(s). Your health plan has contracted with [*insert name of carve out provider, i.e. VSP*] to provide this service.

Your request does not have to be re-submitted for you to receive this service. It can be arranged by you directly without prior authorization by contacting *[name of entity responsible for carved-out service*] at telephone number [*telephone number of responsible entity*] or TDD/TTY number [*TDD/TTY number*] during the hours [*insert hours available*].

If you have any questions, please contact your health plan, [*insert Health Plan name*] at **X-XXX-XXX-XXXX** or TTY/TDD at **X-XXX-XXX-XXXX,** between the hours [*insert hours available*] for further assistance regarding the requested service(s).

Sincerely,

_____
Provider Organization Representative

[Insert all that apply]:
C: Patient File
Requesting Physician
PCP
Health Plan

health net
MEDICARE PROGRAMS

Medicare Advantage *Member* Claim Form

This form may be used by members to file a claim with Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Community Solutions, Inc., Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company. Complete the claim form for each member submitting bills for reimbursement of covered medical services. To avoid any delay, be sure to answer each question completely.

Please attach fully itemized bills and proof of payment or ask your physician to complete Step 2 on pages 2 and 3 of this form.

Step 1: Complete and submit this form to the appropriate address listed for your plan on page 4 of this form. Your plan name can be found on your Health Net Member ID card.

Member information – Member # must be indicated to assure prompt processing of this request.					
Last name:	First name:	MI:	Member #:		Group #:
Residence address:	City:		State:		ZIP:
Date of birth (Mo / Day / Yr):	Phone #:	Email address:			
Marital status: ☐ Married ☐ Single ☐ Domestic partner					
Illness/Injury/Pregnancy information					
Name of referring physician:					
Is the injury or illness work-related? ☐ Yes ☐ No If "Yes," employer's name:			Date accident or illness occurred:		
Other health insurance information					
Is patient presently covered by other medical insurance? ☐ Yes ☐ No					
Name of other insurance company:	Policy #:	Effective date:	Member ID #:		
Insurance company address:	City:		State:	ZIP:	
Name of insured policy holder:	Social Security # (optional):		Date of birth:		
Employer name:	Employer address:	City:	State:	ZIP:	Phone #:

(continued)

Authorization to obtain and release medical information		
I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility to furnish to Health Net, its agents, designees, or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Health Net, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Health Net is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.		
Signature of subscriber: **X**	Name of person preparing form (please print):	Phone #:

Step 2. Physician statement:
If you don't have an itemized bill and proof of payment, please have your physician or supplier complete the following sections, making sure all information is addressed.

Patient information (to be completed by the patient)		
Last name:	First name:	MI:
Release of medical information I authorize the release of any medical information necessary to process this claim. Signature of insured or authorized person (parent or guardian if patient is a minor): **X** Date:	*Assignment of medical benefits* I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature of insured or authorized person: **X** Date:	

Physician or supplier information		
Date of illness (first symptoms) or injury (accident):	Date you were first consulted for this condition:	Has patient ever had the same or similar symptoms? ☐ Yes ☐ No If "Yes," date(s):
Date patient is able to return to work:	Dates of total disability: From: Through:	Dates of partial disability: From: Through:
Name of referring physician:		Hospitalization dates for related services: Admitted: Discharged:
Name and address of facility where services were rendered (if other than home or office):		Laboratory work outside your office: ☐ None ☐ Yes Charges:

(continued)

Diagnosis or nature of illness or injury – Relate diagnosis to procedure in column D by reference to number 1, 2, 3, or 4, or DX code. Please give CPT-4 procedure code in C and ICD-10 in D below.
1.
2.
3.
4.

A Dates of service	B[1] Place of service code	C – Procedures, medical services or supplies furnished		D Diagnosis code	E Charges	F (internal use)
		Procedure code (identify)	Description (explain unusual services or circumstances)			

[1]**Place of service codes:**

11 Doctor's office
12 Patient's home
20 Urgent care facility
21 Inpatient hospital
22 Outpatient hospital
23 Emergency room
24 Ambulatory surgery center
31 Skilled nursing facility
41 Ambulance
55 Residential substance abuse treatment facility
81 Independent laboratory
99 Other place of service

Total charge:

Amount paid:

Balance due:

Signature of physician or supplier: **X**	Accept assignment? ☐ Yes ☐ No (If "Yes," Tax ID # must be given below.)	Physician or supplier name, address, ZIP code, and telephone:
Date:		
Your patient account #:	Physician Tax ID #:	License #:

Submit this form to the appropriate address listed below. Your plan name can be found on your Health Net Member ID card.

• California:

Health Net of California, Inc. (HMO)
PO Box 14703
Lexington, KY
40512-4703

Health Net Community Solutions, Inc.
(HMO and HMO SNP)
PO Box 14703
Lexington, KY
40512-4703

Health Net Life Insurance Company (PPO)
PO Box 14703
Lexington, KY
40512-4703

• Arizona:

Health Net of Arizona, Inc.
PO Box 14730
Lexington, KY
40512-4730

• Oregon/Washington:

(For Oregon and Washington HMO Plans)
Health Net Health Plan of Oregon, Inc.
PO Box 14130
Lexington, KY 40512

Health Net Life Insurance Company (PPO)
PO Box 14130
Lexington, KY 40512

If you have any questions about your Health Net membership, please call Health Net Member Services. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays.

- Arizona: 1-800-977-7522 (TTY: 711)
- California: (HMO) 1-800-275-4737, (PPO) 1-800-960-4638, (HMO SNP) 1-800-431-9007 (TTY: 711)
- Oregon/Washington: 1-888-445-8913 (TTY: 711)

For your protection, Arizona, California, Oregon and Washington laws require the following statements to appear on this form.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Oregon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime and may be subject to denial of insurance coverage, fines, civil damages and confinement in state prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Health Net has a contract with Medicare and the Arizona and California state Medicaid programs, to offer HMO, PPO and HMO SNP coordinated care plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal. Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Community Solutions, Inc., Health Net Health Plan of Oregon, Inc., and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. Health Net is a registered service mark of Health Net, Inc. All rights reserved.

FRM003311EC00 (10/15)

<PPG Name and/or logo>

<Date>

<First Name Initial Last Name>
<Mail Address>
<Mail City, ST Mail Zip>

IMPORTANT NEWS
Your Specialty Provider Will No Longer Be Contracted With <PPG Name or Health Plan Name>

Dear Beneficiary:

We understand that you may currently be receiving care from <***insert Specialist/Ancillary provider name***>**,[<insert specialty>]**. This is to advise you that <***insert Specialist/Ancillary provider name***> will no longer be contracted with <insert PPG name or Health Plan name> as of <***insert effective date***>**.** This termination will impact you if you are undergoing an active course of treatment from this <physician or ancillary provider>.

All requests for continuity of care will be considered on a case-by-case basis and will require prior authorization.

Will Your Medical Benefits Change?
No. All of your benefits and services through your <insert Health Plan name> health plan will remain the same.

Will You Continue to See Your Same Primary Care Physician?
Yes. You will still see the same primary care physician who will continue to coordinate your care.

What Options Are Available To Me For Specialty Care?

- **To transfer care to another specialty provider:**
  Please call your primary care physician to request a referral to another specialty provider within <insert PPG name or Health Plan name>.

[<• **To continue with this specialty provider:**
You may be eligible to continue receiving care from your specialty provider following the termination. Continuation of care may require the terminated specialty provider to agree to the terms and conditions of the contract. Continued care from the terminated specialty provider may be provided for up to ninety (90) days or a longer period if:

1. medically necessary for chronic, serious or acute conditions, or
2. through postpartum for pregnancy related conditions, or
3. until your care can safely be transferred to another provider.

Material ID #Y0035_MULTIPLAN_2013_0487 (H0351, H0562, H5439, H5520, H6815)
CMS Approved 01302013

You may request permission to continue receiving treatment from the terminated specialty provider beyond the termination date by calling:

- <insert Health Plan name> Customer Service at <insert Health Plan customer service number>. (TTY users call < insert 711 or insert Health Plan TTY number>) or, toll free at <insert Health Plan toll free number as applicable> between the hours of < insert applicable office hours>
- Or, your <insert PPG name> Primary Care Physician. <insert Health Plan name> or your <insert PPG Name>'s Medical Director, in consultation with your terminated specialty provider, will determine the best way to manage your ongoing care.>]

[<•**To transfer to another contracting Medical Group/IPA within the <Health Plan Name> network:**

- If you wish to transfer to another Medical Group/IPA**,** please contact <insert Health Plan name> Customer Service at <insert Health Plan customer service number>. (TTY users call < insert 711 or insert Health Plan TTY number>) or, toll free at <insert Health Plan toll free number as applicable> between the hours of < insert applicable office hours>]

If you need further assistance, please contact <insert PPG name> at <insert PPG number> (TTY users call <insert 711 or insert PPG TTY number>) or, toll free at <insert PPG toll free number as applicable> between the hours of < insert applicable office hours>.

Sincerely,

<insert PPG Name>

[Health Net has a contract with Medicare to offer HMO, PPO, and HMO SNP plans.] [Health Net has a contract with Medicare and the State of [<<California/Arizona>>] to offer HMO SNP coordinated care plans.] Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits and/or copayments/co-insurance may change on January 1 of each year.

This information is available for free in other languages. Please contact our customer service number at < insert customer service and TTY numbers and hours of operation >.

Your Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your Plan:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Your Plan's Customer Contact Center at California: 1-800-275-4737 California HMO SNP: 1-800-431-9007 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific Time, seven days a week.

If you believe that Your Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Your Plan's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800–537–7697).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Material ID#: Y0020_2016_0834 Compliance Approved 09202016

Multi-Language Insert

Multi-language Interpreter Services

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (ATS :711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 번으로 전화해 주십시오.

Y0020_2017_0001_A CMS Accepted 08222016

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (رقم هاتف الصم والبكم: 711).

Hindi:
ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) पर कॉल करें।

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)まで、お電話にてご連絡ください。

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
تماس با 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) بگیرید.

Armenian:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY (հեռատիպ)՝ 711):

Cambodian:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)។

Punjabi:
ਧਿਆਨ ਦਓ1 ਤਾਂ ਭਾਸ਼ਾ ਵਾਂਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ,ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ : 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)ਤੇ ਕਾਲ ' ਕਰੋ।

Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Lao:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Serbo-Croatian:
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Ukranian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Assyrian:
ܐܙܘܗܪܐ: ܐܝ ܐܚܬܘܢ ܟܐ ܡܬܡܝܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝ ܒܬܘܢ ܕܦܠܚܬܘܢ ܫܠܡܬܐ ܕܡܬܪܓܡܬܐ
ܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)

Hmong:
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Amharic:
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (መስማት ለተሳናቸው: 711).

Navajo:
Díí baa akó nínízin: Díí saad bee yániłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711.)

Offshore Subcontracting Attestation: Participating Provider

If you are a Health Net of California, Inc., Health Net Community Solutions, Inc. and/or Health Net Life Insurance Company (Health Net) participating provider (also referred to as first-tier, downstream or related entities) using offshore subcontractors, indicate your business name and tax identification (ID) number below.
Name of participating provider (if applicable): **Tax ID:**
If you manage multiple participating providers, list the name(s) and tax IDs for whom you are completing this attestation or attach a separate sheet.
Enter your name, title, phone number, signature, and date that you completed this attestation.
Name: **Title:** **Phone number:** **Signature:** **Date:**

Do you utilize offshore subcontractors? The Centers for Medicare & Medicaid Services (CMS) defines *offshore subcontractor* as follows: "The term subcontractor refers to any organization that a Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. Subcontractors include all first-tier, downstream and/or related entities. The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies." Health Net policy prohibits the transfer or storage of data outside the United States.	**Response:** **Yes** **No**
Do you engage in offshore subcontracting that involves processing, handling or accessing protected health information (PHI)? If "No," the survey is complete and you do not need to complete or submit the attestation. If "Yes," continue completing the form and submit a copy via mail or fax to: Health Net Kristina Rodriguez Director, Provider Network Management Operations Email: Kristina.M.Rodriguez@healthnet.com This form must be completed in full for each new offshore subcontractor, and sent to Health Net within 20 calendar days from the date the contract is signed with the offshore subcontractor to the address or fax number provided above.	**Response:** **Yes** **No**

Offshore Subcontracting Attestation: Participating Provider

Part I. Offshore subcontractor information	
Offshore subcontractor name:	
Offshore subcontractor country:	
Offshore subcontractor address:	
Describe offshore subcontractor functions:	
State proposed or actual effective date for offshore subcontractor (Month, day, year):	

Part II. Precautions for PHI	
Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI and why each alternative was rejected:	

Offshore Subcontracting Attestation: Participating Provider

Part III. Attestation of safeguards to protect beneficiary information in the offshore subcontract		
Item	**Attestation**	**Response: Yes No**
III.1	Offshore subcontracting arrangement has policies and procedures in place to ensure that beneficiary PHI and other personal information remain secure.	
	Participating provider to provide a copy of the policies and procedures that document the process used to ensure the security of beneficiary PHI and other personal information. Copies are provided to Health Net along with this completed attestation.	
III.2	Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with the sponsor's contract with the offshore subcontractor.	
III.3	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	
	Participating provider to provide a copy of the policies and procedures that document the process used for the immediate termination of the subcontract upon discovery of a significant security breach. Copies are provided to Health Net along with this completed attestation.	
III.4	Offshore subcontracting arrangement includes all required Medicare Part C and Part D language, such as record retention requirements, compliance with all Medicare Part C and Part D requirements, etc.	
	Applicable to participating providers contracting with Health Net for the Medicare Advantage line of business – Participating provider to provide a copy of the provider's agreement (proprietary information removed) with the offshore subcontractor. A copy is provided to Health Net along with this completed attestation.	

Part IV. Attestation of audit requirements to ensure protection of PHI		
Item	**Attestation**	**Response: Yes No**
IV.1	Participating provider will conduct an annual audit of the offshore subcontractor.	
	Participating provider to provide a copy of the policies and procedures documenting the process used for conducting annual audits, for monitoring and tracking results, and resolving any identified deficiencies. Copies are provided to Health Net along with this completed attestation.	
IV.2	Audit results are used by the participating provider to evaluate the continuation of its relationship with the offshore subcontractor.	
IV.3	Participating provider agrees to share offshore subcontractors' audit results with Health Net or CMS upon request.	

MEDICARE OUTPATIENT AUTHORIZATION

CALIFORNIA HEALTHNET

Standard/ Expedited Requests:844-501-5713
Transplant Requests: 833-769-1143

Request for additional units. Existing Authorization Units

For Standard requests, complete this form and FAX to 844-501-5713. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

For Expedited requests. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

*** INDICATES REQUIRED FIELD** X

EXPEDITED REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

MEMBER INFORMATION

Last Name, First

Member ID*

Date of Birth *

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

Requesting NPI*

Requesting TIN*

Phone

Requesting Provider Address

Fax*

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing Provider Contact Name

Servicing NPI*

Servicing TIN*

Phone

Servicing Provider/Facility Name Address

Fax

City, State, Zip

AUTHORIZATION REQUEST

Primary Procedure Code* (Modifier)

(CPT/HCPCS)

Additional Procedure Code (Modifier)

(CPT/HCPCS)

Start Date OR Admission Date*

(MMDDYYYY)

Diagnosis Code*

(ICD-10)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

End Date OR Discharge Date

(MMDDYYYY)

Total Units/Visits/Days

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home health
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
141 Imaging
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
422 Biopharmacy
428 Second Opinion
997 Office Visit/Consult

DME (Orthotics and Prosthetics)

120 Purchase
417 Rental (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Health Net Contracted Palliative Care Providers			
Ancillary Name	**Address**	**Phone**	**Service Type**
Assisted Home Hospice – North Hills	10550 Sepulveda Blvd, Suite 101 Mission Hills, CA 91345	818-830-5003	Hospice
Assisted Home Hospice – Ventura	4450 Westinghouse Street, Suite 103 Ventura, CA 93003	805-677-7405	Hospice
Assisted Home Hospice – Los Angeles	3731 Wilshire Blvd, Suite 518 Los Angeles, CA 90010	213-355-3511	Hospice
Assisted Home Hospice – Santa Barbara	115 E Micheltorena St, Suite 100 Santa Barbara, CA 93101	805-569-2000	Hospice
Carechoices Hospice and Palliative Services, Inc.	20 Corporate Park, Suite 300 Irvine, CA 92606	949-777-8600	Hospice
Community Hospice, Inc.	4368 Spyres Way Modesto, CA 95356	209-578-6300	Hospice
Hinds Hospice	2490 W Shaw Ave, Suite 101 Fresno, CA 93711	559-226-5683	Hospice
Hinds Hospice	1416 W Twain Ave Fresno, CA 93711	559-222-0793	Hospice
Hinds Hospice	410 W Main St, Suite A Merced, CA 95340	209-383-3123	Hospice
Hoffman Hospice Of The Valley, Inc.	4325 Buena Vista Rd Bakersfield, CA 93311	661-410-1010	Hospice
Hospice of East Bay	3470 Buskirk Ave Pleasant Hill, CA 94523	925-887-5678	Hospice
Hospice of East Bay	2849 Miranda Ave Alamo, CA 94507	925-945-8924	Hospice
Hospice of The Foothills	11270 Rough and Ready Hwy Grass Valley, CA 95945	530-272-5739	Hospice
Libertana Home Health	5805 Sepulveda Blvd, Suite 605 Sherman Oaks, CA 91411	800-750-1444	Hospice
MedZed Palliative Care – California	300 Corporate Pointe, Suite 465 Culver City, CA 90230	323-203-0070	Home Health

*Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Health Net Contracted Palliative Care Providers, continued			
Ancillary Name	**Address**	**Phone**	**Service type**
Lightbridge Hospice, LLC	6155 Cornerstone Ct E, Suite 220 San Diego, CA 92121	858-458-2992	Hospice
Noble Hospice Care, Inc.	41305 Albrae St., Suite A Fremont, CA 94538	510-683-9100	Hospice
Prohealth Home Care	2700 Zanker Rd, Suite 180 San Jose, CA 95134	408-451-9055	Home Health
Prohealth Home Care – Sacramento	1375 Exposition Blvd, Suite 250A&B Sacramento, CA 95815	877-667-8770	Home Health
Prohealth Home Care, Inc.	1776 W. March Ln, Suite 400A&B Stockton, CA 95207	877-311-5001	Home Health
Prohealth Home Care – Walnut Creek	2125 Oak Grove Rd, Suite 124A&B Walnut Creek, CA 94598	925-933-2565	Home Health
Providence TrinityCare Hospice	17315 Studebaker Rd, Suite 101 Cerritos, CA 90703	562-402-3336	Hospice
ResolutionCare, Pc	517 3rd St, Suite 2 Eureka, CA 95501	707-442-5683	Hospice
Roze Room Hospice	5000 Overland Ave, Suite 101 Culver City, CA 90230	310-202-7693	Hospice
Roze Room Hospice	2700 E Foothill Blvd, Suite 200 Pasadena, CA 91107	626-446-7673	Hospice
Roze Room Hospice	4510 E Pacific Coast Hwy, Suite 320 Long Beach, CA 90804	562-597-8273	Hospice
Roze Room Hospice	18107 Sherman Way, Suite 100 Reseda, CA 91335	818-783-1002	Hospice
Roze Room Hospice	5675 Ralston St., Suite C Ventura, CA 93003	805-654-0191	Hospice
Snowline Hospice of El Dorado County, Inc.	6520 Pleasant Valley Rd Diamond Springs, CA 95619	530-621-7820	Hospice
The Elizabeth Hospice	500 La Terraza Blvd, Suite 130 Escondido, CA 92025	760-737-2050	Hospice

[ENTITY NAME & LOGO]

CMS CLAIMS DISPUTE RESOLUTION
Adjustment/Payment Made

Date:

Provider:

Member Name:
Date of Service:
Total Billed Amount:
[Claim, tracking, document] #:
PDR Date Received:
Health Plan ID# (optional)
Patient Account# (optional)

Dear Provider:

[ENTITY NAME] received a claim dispute regarding the claim referenced above. Upon careful review of this dispute, we have determined that the initial claim decision is being overturned and payment will be made.

Payment in the amount of $_____ is made for the following service(s):

Either list line items or a description of service must be given for reason for payment.

If you require further information regarding the resolution of this dispute, please contact the [INSERT Entity unit and contact information].

You have the right to request an additional decision from Health Net. Please forward all information regarding this claim to:

Medicare Provider Disputes
PO Box 9030
Farmington, MO 63640-9030

Health Net must receive the written request within 180 days from the date of the notification.

Sincerely,

[ENTITY NAME]
[Responsible unit]

[ENTITY NAME & LOGO]

CMS CLAIMS DISPUTE RESOLUTION
Original Claim Determination Upheld

Date:

Provider:

Member Name:
Date of Service:
Total Billed Amount:
[Claim, tracking, document] #:
PDR Date Received:
Health Plan ID# (optional)
Patient Account# (optional)

Dear Provider:

[ENTITY NAME] received a claim dispute regarding the claim referenced above. Upon careful review of this dispute, we have determined that the initial claim decision **is being upheld** for the following reason(s):

❑ Medicare rate paid at Area XX YEAR; and no additional amount is due.
❑ Additional information requested on Month date, year was never received.
❑ Other

This dispute process is now closed, but if you require additional information regarding the resolution of this dispute, please contact the [INSERT Entity unit and contact information]. Please use the [Claim, tracking, document] number to reference the claim.

You have the right to request an additional decision from Health Net. Please forward all information regarding this claim to:

Medicare Provider Disputes
PO Box 9030
Farmington, MO 63640-9030

Health Net must receive the written request within 180 days from the date of the notification.

Sincerely,

[ENTITY NAME]
[Responsible unit]

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Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Do not photocopy this form. The information contained is confidential and peer-review protected.

Check one:

☐ Medical/physical medicine PQIs (Complete all fields and forward immediately **via secure fax: 877-808-7024**)
☐ Behavioral health PQIs (Complete all fields and forward immediately **via secure email: pqi@healthnet.com**)

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

Important

The PQI Referral Form is a confidential document used by the Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to Health Net enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner.

Refer issues identified as *member appeals* or *member grievances* to the Member Appeals and Grievances Department for appropriate case handling and resolution.

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

Referral Content

1. All the fields on the PQI form are **required** fields.
2. Use the fillable PDF form to complete the PQI referral. Do not fax a handwritten PQI referral form. Handwritten PQI forms will be returned to originator for proper re-submission.
3. All sections of the PQI referral must be completed.
4. The form should be completed as follows:
    a) Referral source - Include referral date, first and last name of the associate completing the referral, contact information (telephone number, fax number) and the name of the associate who identified the PQI. If same as the referred by, enter *same as referred by* in this section.
    b) Member demographics – Include member first and last name, member ID, member's current primary care physician (PCP) and the associated participating physician group (PPG).
    c) PQI Event Dates / Filed Against Details – Include date of event, first and last name of practitioner that PQI is filed against (if same as PCP, re-enter PCP and PPG name here) and practitioner's office location. If hospital, please include name of hospital and location. Provide an admission date. Indicate the type of PQI using the check box items provided on the PQI referral. In the description of event field, describe event(s) chronologically, including dates, provider or practitioner names, specify any equipment or medication involved, quote relevant statements made by the provider or others and provide a complete explanation describing the potential deviation in the standard of care.
5. Complete and submit this report directly within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
6. Incomplete referral forms are returned to the associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

Referral Source

Referral date:_____

Referred by *(First, Last Name)*: _____

Identified by *(First, Last Name)*: _____

Phone number: _____

Fax number: _____

Member Demographics

Member name *(Last, First, MI)*: _____

ID#: _____

Current primary care physician (PCP): _____

Current participating physician group (PPG): _____

PQI Event Dates

Date(s) of PQI event:_____

Admission date:_____

Prior admission dates (if applicable): _____

_____

Filed Against Details:

Provider/Practitioner name: *(First, Last or name of facility)*: _____

Associated Provider/Practitioner PPG: _____

Provider/Practitioner location: _____

Provider/Practitioner NPI#:_____

HAC/HCAC, OPPC, SRAE, & and other PQI Indicators

Surgical events:

- ☐ **Surgery on wrong body part**
- ☐ **Surgery on wrong patient**
- ☐ **Wrong surgical procedures on a patient**
- ☐ **Foreign object retained after surgery**
- ☐ Anesthesia adverse event
- ☐ **Surgery with post-operative/intra-operative death in a normal healthy patient**
- ☐ Acute MI or CVA within 48 hours after elective surgery
- ☐ Cardiac or respiratory arrest in the operating room (OR)
- ☐ Unplanned return to OR, unplanned removal, injury or repair of an organ
- ☐ Other (explain) _____

Surgical site/post-operative infections:

- ☐ **Mediastinitis after coronary artery bypass graft (CABG)**
- ☐ **Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)**
- ☐ **Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip**
- ☐ Other (explain) _____

Bolded text indicates HAC/HCAC, OPPC or SRAE

Patient death/disability:

- ☐ Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- ☐ Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- ☐ Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended
- ☐ Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- ☐ Unexpected death (Please explain) _____

Patient issue:

- ☐ Member leaves against medical advice (AMA) when there is a potential for serious adverse event(s)
- ☐ Patient suicide attempt or serious injury to self while in treatment
- ☐ Other (explain)_____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Hospital-acquired (nosocomial) infections:

- ☐ **Catheter-associated urinary tract infection (UTI)**
- ☐ **Vascular catheter-associated Infection**
- ☐ Other (explain) _____

Deep vein thrombosis or pulmonary embolism following orthopedic procedures:

- ☐ **Total knee replacement**
- ☐ **Total hip replacement**
- ☐ Other (explain) _____

Falls (with trauma):

- ☐ **Fractures**
- ☐ **Dislocations**
- ☐ **Intracranial injuries**
- ☐ Other (explain) _____

Injury:

- ☐ **Crushing injuries**
- ☐ **Burns**
- ☐ **Electric shock**
- ☐ Other (explain) _____

Manifestations of poor glycemic control:

- ☐ **Diabetic ketoacidosis**
- ☐ **Nonketotic hyperosmolar coma**
- ☐ **Hypoglycemic coma**
- ☐ **Secondary diabetes with ketoacidosis**
- ☐ **Secondary diabetes with hyperosmolarity**

Obstetrics:

- ☐ Nonmedically indicated (elective) delivery less than 39 weeks gestational age
- ☐ Newborn Apgar < 4 at 1 minute or < 6 at 5 minutes

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Admission/readmission/discharge:

- ☐ Unexpected / unanticipated readmission within 30 days to acute level of care with same or similar diagnosis or as a complication of the previous admission
- ☐ Unplanned admission following diagnostic test or outpatient procedure
- ☐ Neurological deficit present at discharge not present on admit
- ☐ Delay in transfer/treatment or discharge – which results in a poor outcome to the member or additional costs to the plan
- ☐ Delayed diagnosis or missed diagnosis – resulting in adverse member outcome or extended hospital stay
- ☐ **Infant discharged to the wrong person**

Outpatient/ambulatory care:

- ☐ Breach of member confidentiality or ethics concern/violation
- ☐ Abnormal diagnostic study not followed up appropriately where the potential for adverse outcome exists
- ☐ Inattention to or lack of appropriate follow-up of consultant's major recommendations without appropriate rationale
- ☐ Practitioner's failure to follow-up on any member's significant complaint or physical finding within a reasonable period of time
- ☐ Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
- ☐ Hospitalization resulting from inappropriate drug therapy

Other:

- ☐ Pressure ulcer stages III & IV occurring after hospital admission
- ☐ Air embolism
- ☐ Blood transfusion incompatibility
- ☐ Any substandard care with the potential for harm to the member (please explain fully) _____
- ☐ Member refused to file a grievance
- ☐ Grievance withdrawal
- ☐ Other (select only when no other selection is applicable and explain fully) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS	BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Behavioral health:

- ☐ Inadequate assessment
- ☐ Inadequate treatment strategy or intervention
- ☐ Quality of patient relationship with provider appears very poor
- ☐ Inadequate discharge planning or follow-up
- ☐ Failure to utilize appropriate collateral contacts and/or coordinate care
- ☐ Lack of timely intervention that doesn't involve medication
- ☐ Patient's condition requires medication evaluation, but no referral was made
- ☐ Incident of drug/alcohol use in a facility
- ☐ Incident of possession of a weapon in a facility
- ☐ Situation where provider/facility acted in such a way as to create potential safety concerns
- ☐ Patient assaulting or causing serious injury to other or other criminal activity
- ☐ Use of restrictive interventions (seclusion, restraints, isolation) inconsistent with accepted standards and regulations
- ☐ Clinical risk inadequately assessed or managed
- ☐ Medication error, incident or concern
- ☐ Alleged abuse of child, adolescent or elder not reported to appropriate authorities

Description of event:
Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary – must be typed, not handwritten):

*Health Net Community Solutions, Inc. is subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Health Net (HMO SNP)

Pre-enrollment Qualification Assessment Tool

Health Net is a Medicare Advantage Special Needs Plan (SNP) designed for people with chronic conditions such as diabetes, chronic heart failure and certain cardiovascular disorders.

Enrollee information

Last name: First name: MI:

Medicare ID number (HICN): Phone number: – –

Birth date:

M M D D Y Y Y Y

Please complete and submit this form with your enrollment application. If you can answer "Yes" or "Not sure" to any of the following questions, you may be eligible to join our chronic care SNP. When this form is completed and submitted along with an enrollment application, you will be enrolled into Health Net. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from the Special Needs Plan.

Chronic condition questions

Have you been diagnosed with diabetes? ☐ Yes ☐ No ☐ Not sure

Have you had problems with high blood sugar? ☐ Yes ☐ No ☐ Not sure

Do you take medication and/or have you been put on a special diet to control your blood sugar? ☐ Yes ☐ No ☐ Not sure

Have you been diagnosed with chronic (or congestive) heart failure (CHF)? ☐ Yes ☐ No ☐ Not sure

Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem? ☐ Yes ☐ No ☐ Not sure

Do you take medication to prevent fluid retention? ☐ Yes ☐ No ☐ Not sure

Have you been diagnosed with any of the following cardiovascular disorders? ☐ Yes ☐ No ☐ Not sure

- Cardiac arrhythmia
- Chronic venous thromboembolic disorder
- Coronary artery disease
- Peripheral vascular disease

Have you had problems with rapid, erratic heartbeats? ☐ Yes ☐ No ☐ Not sure

Have you had problems with chest pain or tightness, shortness of breath, heart attack, or stroke? ☐ Yes ☐ No ☐ Not sure

Has a physician ever told you that you have a blood clot? ☐ Yes ☐ No ☐ Not sure

(continued)

Health care provider(s) who can verify your chronic condition(s)

PROVIDER #1

Provider name:

Provider address:

Provider phone: – –

Provider fax: – –

PROVIDER #2

Provider name:

Provider address:

Provider phone: – –

Provider fax: – –

Authorization for Disclosure of Health Information to Verify Chronic Condition(s):

I hereby authorize the disclosure of my health information by the providers listed above to Health Net in order to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in Health Net Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Information disclosed as a result of this authorization will be protected by Health Net in accordance with applicable state and federal laws and requirements.

Signature

Enrollee signature:

Date: M M D D Y Y Y Y

Broker/Agent name (if applicable):

Broker/Agent signature (if applicable):

Date: M M D D Y Y Y Y

For more information or for assistance with this form, please call Member Services at the following toll-free number:

California: 1-800-431-9007 (TTY: 711)

Hours of operation: From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays.

Health Net has a contract with Medicare to offer HMO SNP plans. Enrollment in a Health Net Medicare Advantage plan depends on the renewal of this contract.

FRM013584EK00 (8/17)

Primary Care Services Eligible for Primary Care Incentive Payments in Calendar Year 2011

CPT Codes	Description
99201	Level 1 new patient office or other outpatient visit
99202	Level 2 new patient office or other outpatient visit
99203	Level 3 new patient office or other outpatient visit
99204	Level 4 new patient office or other outpatient visit
99205	Level 5 new patient office or other outpatient visit
99211	Level 1 established patient office or other outpatient visit
99212	Level 2 established patient office or other outpatient visit
99213	Level 3 established patient office or other outpatient visit
99214	Level 4 established patient office or other outpatient visit
99215	Level 5 established patient office or other outpatient visit
99304	Level 1 initial nursing facility care
99305	Level 2 initial nursing facility care
99306	Level 3 initial nursing facility care
99307	Level 1 subsequent nursing facility care
99308	Level 2 subsequent nursing facility care
99309	Level 3 subsequent nursing facility care
99310	Level 4 subsequent nursing facility care
99315	Nursing facility discharge day management; 30 minutes
99316	Nursing facility discharge day management; more than 30 minutes
99318	Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment
99324	Level 1 new patient domiciliary, rest home, or custodial care visit
99325	Level 2 new patient domiciliary, rest home, or custodial care visit
99326	Level 3 new patient domiciliary, rest home, or custodial care visit
99327	Level 4 new patient domiciliary, rest home, or custodial care visit
99328	Level 5 new patient domiciliary, rest home, or custodial care visit
99334	Level 1 established patient domiciliary, rest home, or custodial care visit
99335	Level 2 established patient domiciliary, rest home, or custodial care visit
99336	Level 3 established patient domiciliary, rest home, or custodial care visit
99337	Level 4 established patient domiciliary, rest home, or custodial care visit
99339	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes
99340	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more
99341	Level 1 new patient home visit
99342	Level 2 new patient home visit

CPT Codes	Description
99343	Level 3 new patient home visit
99344	Level 4 new patient home visit
99345	Level 5 new patient home visit
99347	Level 1 established patient home visit
99348	Level 2 established patient home visit
99349	Level 3 established patient home visit
99350	Level 4 established patient home visit

BE INFORMED

If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment pursuant to Section 1704.7 of the California Health & Safety Code.

The information about methods of treatment was developed by the State Department of Health Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures.

INFÓRMESE

Si es usted un paciente que está recibiendo tratamiento contra cualquier forma de cáncer de próstata, o en la etapa prévia a una biopsia por cáncer prostático, su médico o cirujano está urgido dar a usted un sumario escrito de los métodos alternativos de tratamiento disponibles considerados eficaces. Esto es en cumplimiento con la Sección 1704.7 del Código de Salud y Seguridad del Estado de California.

La información sobre los métodos de tratamiento fueron desarrollados por los Servicios de Salud del Estado de California para informar a los pacientes sobre las ventajas y desventajas, riesgos y descripciones de los procedimientos.

通知

如果你是前列癌病患者或如要进行前列腺癌的切片測驗，按照加省衛生安全規則第 1704.7 部份，你的醫生必要向你提供一份有關各種有效治療的報告書。

各種治療的資料是由國家衛生服務局所提供，來使病人知道各種不同治療的好處、壞處、危險和治療的程序。

Provider Dispute Resolution Request

Medicare Advantage

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-929-9224.
- Mail the completed form to the following address.

  Health Net Medicare Provider Appeals Unit
  PO Box 9030
  Farmington, MO 63640-9030

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab ☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute ☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

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20-691/FRM047549EC00 (9/20)

Medicare Advantage Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-929-9224.
- Mail the completed form to the following address.

  Health Net Medicare Provider Appeals Unit
  PO Box 9030
  Farmington, MO 63640-9030

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

20-691/FRM047549EC00 (9/20)

CENTENE Corporation

CodySoft Project # _____
Note: Material ID to be assigned by Medicare Material Regulatory Reviewer

MA & MMP Material Review/Submission Checklist

General Information (The material will be returned if the checklist is incomplete, contains missing, abbreviated, or incorrect information.)

1. Name/Title of Material:			
2. Material Originator: (person submitting in CodySoft)		**2a. Phone Number:**	**2b. Department:**
3. Material Audience: (Check All that apply) ☐ Centene plan use ☐ Agent/Broker use ☐ Employer Group ☐ Member ☐ Prospect ☐ Provider use ☐ Other (describe in #8)	**4. Distribution Period(s):** (Check All that apply) ☐ Pre-AEP ☐ AEP ☐ MADP ☐ SEP ☐ Year Round ☐ Other (describe in #8)	**5. Contract Year:** (Check All that apply) ☐ CY 2017 ☐ CY 2018 **6. Was a CMS model / template available?** (Include models in Zip file) ☐ YES (also complete side 2) ☐ NO	**7. Section 1557 /NDL*:** (Check All that apply) ☐ N/A (not applicable) ☐ MLI/NDL Insert used* ☐ NDL on Material* ☐ Larger than 8 ½ x11 ☐ Smaller than 8 ½ x11 ☐ Tri-fold (panel) ☐ Other (describe in #9) *NDL – Non-Discrimination Language, MLI – Multi Language Insert
8. Material Purpose, Use and Intent:	*Provide detailed explanation of how the material will be used, its purpose and/or intent. Make sure to note any yellow highlights due to changed model text or revisions to recently approved materials.*		
9: Additional Instructional Information: *Any additional instructional information that the Centene or CMS reviewers would need to know (such as identifying other supporting documents in Zip file, rationale for Section 1557/NDL or MLI use, template filing, etc.)*			
10. Is this a Multi-Plan Sponsor MA Material per MMG Section 90.2.3?	☐ Yes ☐ No	**10a. Lead Plan Sponsor Information.** **If yes, please provide:** Lead Plan (LP) Sponsor name, LP material ID, LP Approval Date, Name and role of Coordinating Entity (CE)	
11. Alternate/Populated Version(s): (Zip files must include translated or alternate format attestations from the vendor) ☐ Alternate Format (provide format): ☐ Translated Language (provide language):	☐ Populated Template (provide version #): ___ of ____ (Populated version(s) containing ***benefits, cost sharing or premiums*** must be submitted in CodySoft as a new project(s) within 30 days of use)		
12. Previous Version History (Original / English material, Approved Template):	Material ID #:	Approval/File Date:	
13. Corporate Functional Business Lead Approval ? (Corporate review & approval required for Plan level materials = CodySoft ready)	☐ **Yes** (also complete 13a) ☐ **No, Corporate submission**	**13a. Corp. Functional Business Lead:** Name? Dept.?	

14. Material Attestation Section (If any of the items below are determined as "Not Met" by Compliance, the material will be returned.)

REVIEWED FOR: (Check All that apply) ☐ **Medicare Advantage (MA)** ☐ **Medicare-Medicaid Plan (MMP)**	**MA = CMS Marketing Manual Section #**	**MMP State Marketing Manual Section #** (MMP only)	**ORIGIN-ATOR**	**N/A**	**MCDR Review Met**	**Not Met**
Used Plan Type Identifier	40.10	40.10	☐	☐	☐	☐
Did not use "Seniors" or "Traditional Medicare"	40.4/90.1	←	☐	☐	☐	☐
Did not use absolute "superlatives"	40.4/90.1	←	☐	☐	☐	☐
Font = 12 pt TNR equivalent/14 pt for MMP Health Ed	40.2	APL 11-018 (for CA)	☐	☐	☐	☐
Correct cost sharing amounts	40.4/90.1	←	☐	☐	☐	☐
Did not use "free" when describing cost sharing	40.4/90.1	←	☐	☐	☐	☐
Contain Phone / TTY / State Relay "711"	40.7	←	☐	☐	☐	☐
Phone numbers same font/style/TTY	40.7	←	☐	☐	☐	☐
Hours of Operation	40.6	40.6	☐	☐	☐	☐
Correct Disclaimers & Footnotes	50	50	☐	☐	☐	☐
Disclaimers/Footnotes size = body text	40.2	←	☐	☐	☐	☐
<Carets> = variable text. [Brackets] = adding or deleting info.	90.8	←	☐	☐	☐	☐
MMP Material is at a 6th grade reading level		3-way Contract (Ex: § 2.9.10.8.4 for CA)	☐	☐	☐	☐
MMP Compliance w/MOU and/or 3-way contract		MOU/ 3-way contract	☐	☐	☐	☐
Understandable Content, Typos / Grammar, Correct business Entity(s)	40.4, 90.1	3-way Contract (Ex: § 2.9.10.8.4 for CA)	☐	-	☐	☐
Supporting Documentation	10	←	☐	☐	☐	☐

CENTENE Corporation

CodySoft Project # _____
Note: Material ID to be assigned by Medicare Material Regulatory Reviewer

MA & MMP Material Review/Submission Checklist

Compliance Reviewer _____ Date _____

Model/Non-Model Materials (only complete this page if you answered "YES" to box 6)

15. Is the Centene version still model?	☐ Yes (model)	☐ No (non- model)
16. If "No" please explain in detail why it was modified from the CMS model.	*If no, please explain in detail why the text/format was modified from the CMS model. Also acknowledge that revised model text / formatted areas have been highlighted in yellow (or note removal of model text here).*	
17. CMS Model Name:	**18. CMS Model Number (Exhibit, OMB, CMS Form, etc.):**	**19. CMS Source:**

ATTACH THE CMS MODEL VERSION WHEN SUBMITTING THIS FORM FOR MODEL AND NON-MODEL DOCUMENTS.

Complete only if non-model marketing material was created when a CMS model exists:

As Vice President of this Centene Corporate functional business area, I:

- **Authorize the use of a non-model version of this Marketing Material when a CMS model was made available for the reason provided on this form.**
- **Attest that all components of the CMS model exist in this non-model document.**
- **Understand that CMS Region X has commented during past audits that Centene needs to utilize more CMS models and templates.**
- **Have read and understand Centene's internal policy (MCARE.MCDR.01) for the use of model and non-model Marketing Materials. Originators will follow Centene policy to use CMS model documents. Refer to the Section 90.7 (and its sub sections) of the CMS** "Chapter 3 – Medicare Marketing Guidelines".
- **Provided the appropriate documentation in the CodySoft file that supports my decision to use a non-model material.**
- **Assume all risk of non-compliance for my area which may be caused by the use of this non-model material.**
- **Understand that this non-model material qualifies for a standard 45 day CMS review and that it runs the risk of not being approved.**

20. Signature (Must be signed by VP of functional/operational area):	**21. Date:**
22. Print VP Name:	
23. VP Title:	

NOTE: Centene's MMRR (Medicare Material Regulatory Reviewer) will decide, after review, whether or not to submit this non-model material to CMS (and with Corporate Compliance on risks involved, if necessary).

Material Development Resources

- Centene Intranet Website (SharePoint): https://cnet.centene.com/sites/MedicareSNP/Member_and_MarketingMaterials/Lists/Medicare%20Marketing%20Materials%20Final%20Documents/AllItems.aspx
- CMS Marketing Guidelines website: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
- Additional guidance may include: CMS memos, current Call Letter, the Medicare Marketing Guidance (MMG) and/or other CMS regulatory requirements, and any other applicable Federal or State agency regulatory instruction (i.e. HIPAA, Medicaid, OCR, Section 1557, etc.)

MA & MMP Material Review/Submission Checklist

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net)
Quick Reference Guide

eviCore healthcare administers the utilization management program for all outpatient MRI/MRA, CT/CTA, PET imaging studies, nuclear cardiac imaging procedures, including single photon emission computed tomography (SPECT), and sleep studies for all HMO, CommunityCare HMO, EPO, PPO, and Medicare Advantage (MA) Direct Network/Fee-for-Service members.

Imaging procedures performed during an inpatient admission or emergency room visit are NOT included in this program.

All of the outpatient imaging services listed above will be evaluated based on the applicable terms of the health benefit plan (including, but not limited to, medical necessity) and require prior authorization by eviCore healthcare. Services will be authorized for covered imaging studies performed at a facility within the Health Net network.

eviCore healthcare will respond to requests for prior authorization within two business days once complete clinical information is received.

Prior Authorization Process

There are three ways to request prior authorization for an imaging procedure from eviCore healthcare:

1. **Internet**
   Complete the Internet-based submission form by logging on to the secure Web site at **www.evicore.com.**

2. **Telephone**
   Contact eviCore healthcare toll-free, 5:00 a.m. to 6:00 p.m. PST, Monday through Friday at **(888) 693-3211** and give all pertinent clinical information over the telephone. Outside of these normal business hours, you may call eviCore healthcare and leave a voice mail for a return call the next business day. When calling eviCore healthcare with a request for prior authorization, please have the following information available:
   - Member demographic information, including Health Net member ID and date of birth
   - Current diagnosis and clinical information, including treatment history, treatment plan and medications
   - Member's chart and previous imaging study results

3. **Fax**
   Complete the demographics box at the top of the fax form and **include the office notes/previous imaging reports** for the member and fax your request to eviCore healthcare at (888) 693-3210.

Coverage Authorizations

Your request for prior authorization will be processed **within two business days** after the receipt of all necessary information. Once coverage is approved, an authorization number will be faxed to the ordering physician and requested facility, and mailed to the member. Please note: eviCore healthcare will specifically approve both the facility to perform the imaging study and the CPT code or codes for the diagnostic imaging.

Coverage Denials
If a request for prior authorization is denied, an eviCore healthcare representative will call the ordering physician's office and verbally communicate the denial determination and the rationale for the denial. The ordering physician may request a reconsideration of the denial decision by either faxing additional information or discussing the denial determination with the eviCore healthcare physician reviewer. Written notification of the final determination will be faxed to the requesting physician and mailed to the member. The written notification will include information about the member appeal rights.

Peer Review
Referring physicians or radiologists may request a peer review discussion of a denial decision with one of MedSolutions' physician reviewers. To request a peer review, call eviCore healthcare at (888) 693-3211 during normal business hours of 5:00 a.m. to 6:00 p.m. PST, Monday through Friday.

Expedited Requests
If the referring physician believes a medical emergency is occurring, prior authorization is not required for diagnostic imaging studies performed on an outpatient, emergent basis. eviCore healthcare physician reviewers will retrospectively review the request and the clinical documentation supporting the nature of the medical emergency.

MEDICALLY URGENT: For those situations where advanced imaging is required on the same day due to a medically urgent condition, **call** eviCore healthcare at **(888) 693-3211** for prior authorization. Have the pertinent clinical office notes, the member's chart and previous imaging study results available for reference during your call. eviCore healthcare will render a decision within **four hours of receipt** of all necessary information. Please clearly indicate that the prior authorization request is for **medically urgent care**.

eviCore healthcare Web-Based Services
You may access eviCore healthcare online for day-to-day transactions and services. To reach eviCore healthcare online services please go to the Web site, **www.evicore.com**, select your professional group and follow the online instructions. Here you may sign up for access to a variety of eviCore healthcare services, including prior authorization guidelines. Please be sure to watch the Web site for news of future online initiatives.

Fax Forms
You can request additional copies of the fax form by accessing the eviCore healthcare Web site at **www.evicore.com** or by calling the eviCore healthcare Customer Service Department toll-free at **(888) 693-3211, option # 3.**

Medicare Advantage Transition to MHN
Quick Reference Sheet

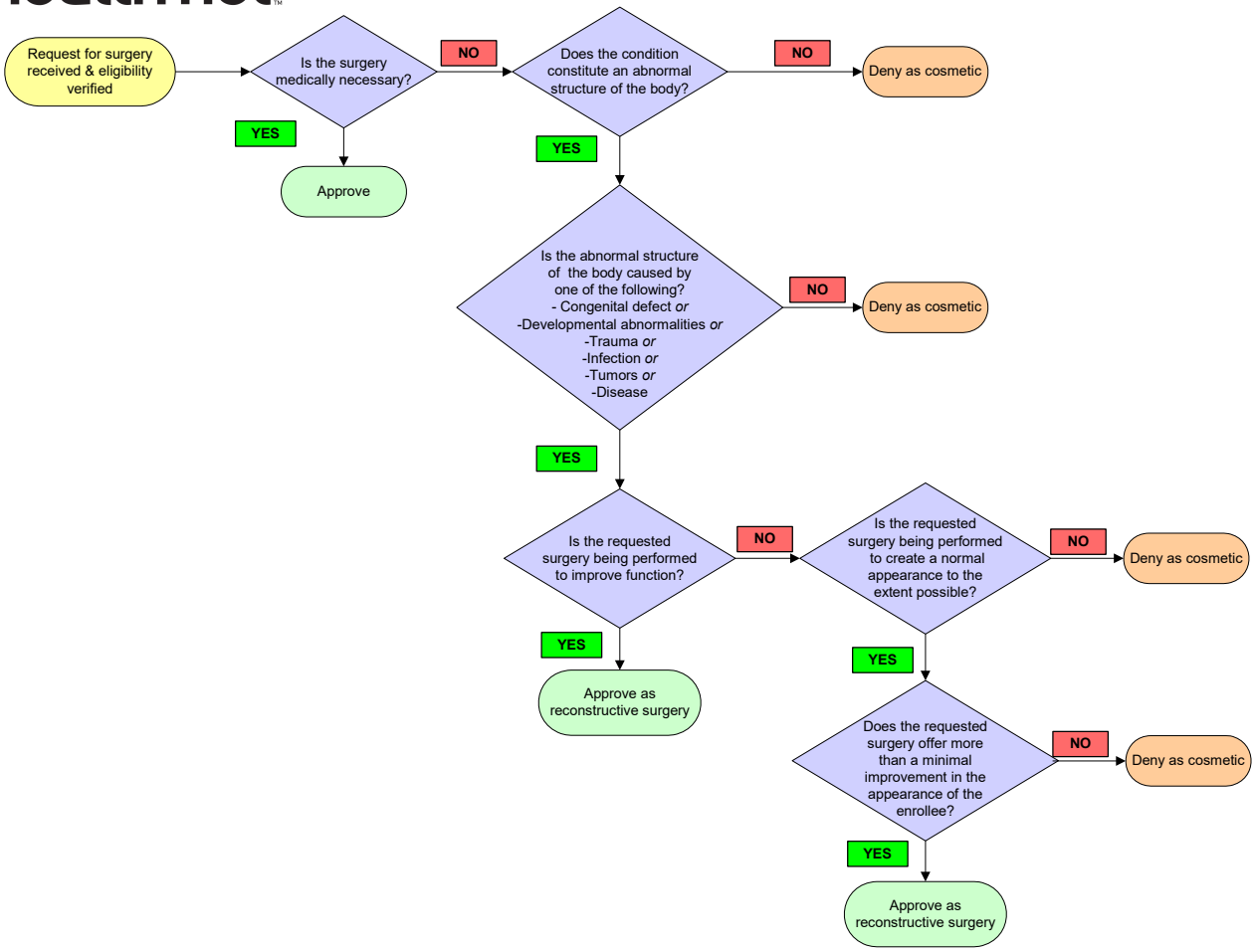
For office use only. Do not display or distribute to patients.

MHN	
Transition Services	Contact Information
Behavioral health and substance abuse services Referral and intake process for transition and continuity of care assistance MHN provider directory or practitioner search Cal MediConnect	(800) 646-5610 – providers and members (800) 327-0801 (TDD/TTY) www.mhn.com (855) 464-3571
Claims for behavioral health or substance abuse services for Medicare Advantage members	MHN Claims Department P.O. Box 14621 Lexington, KY 40512-4621
MHN Provider Contracting	(800) 541-3353
MHN Customer Service Department	(800) 646-5610
MHN Physician Help Line	(800) 289-2040

Health Net Provider Services Center	
Transition Services	Contact Information
Information regarding the transition to MHN Information regarding Medicare Advantage benefits and services MHN's practitioner search can also be accessed through the Health Net Web site Cal MediConnect	(800) 929-9224 – providers only provider.services@healthnet.com www.healthnet.com 8:00 a.m. – 5:00 p.m. Monday through Friday, except holidays (855) 464-3571

Health Net Member Services Center	
Transition Services	Contact Information
Information regarding the transition to MHN Information regarding Medicare Advantage benefits and services MHN's practitioner search can also be accessed through the Health Net Web site Cal MediConnect	(800) 275-4737 – members only (800) 929-9955 (TDD/TTY) www.healthnet.com 7:30 a.m. – 12:00 p.m. 1:00 p.m. – 5:00 p.m. Monday through Friday, except holidays (855) 464-3571 (888) 788-6382 TTY 24 hours a day, 7 days a week

Reconstructive Surgery Decision Tree



REMITTANCE DETAIL REPORT FIELD DESCRIPTIONS

Field	Description
Header Information	
Report BRM 20	A Health Net-assigned number for the Remittance Detail Report
Report Title	The name of the report
Date	The day/month/year that the report was system generated
Page Number	The page number of the report
Provider ID	Three- or Four-digit number Health Net assigns to each PPG
Provider Name	Name of the PPG
Provider Address	Address of the provider.
Provider Phone Number	Phone Number of the provider.
Report Information	
Member Name	First and last names, and middle initial of the member
Member Sex Code	A single-digit code indicating the gender of the subscriber: • M= male • F= female
Member ID	Reports for commercial providers will have subscriber's ID/Ref ID number as shown on the Health Net ID card (usually the subscriber's Social Security number) Reports for medi-cal providers will have CIN Number(subscriber's client identification number)replaced for subscriber's ID/Ref ID
Group ID #	A eight-position code assigned to each employer group
PR TY	A single-letter code that identifies the product type of the member's employer group: • M = Standard HMO • N = POS HMO
Plan Code	A three-position code that identifies the type of benefits chosen by the employer group
Product code	A 3 or 4 position code that identifies the product type. Example, MDE, MLA, MCR, SDE, INDV
Contract Type	A single-digit code indicating the member sex • M= male • F= female
Member risk	A single digit code for the member's risk status for Part A, Medicaid, member status, working aged, Medicaid Add-on, Disabled, Default Risk Factor & Dialysis Indicator (refer to Member Status Table below for values)
PIP / DCG Code	A two character code for PIP / DCG Code. It stands for principal inpatient diagnostic cost groups
SCC Code	State county code
Date of Birth/Age	The member's date of birth and the member's age at the end of the reporting month
PHYS ID	The physician ID # of the member assigned by Health Net
Provider ID	The name of the PPG and the three- or four-digit number Health Net assigns to each PPG
Capitation Detail	All current and retroactive adjustments to the capitation remittance
Month	The effective date of the adjustment
Description	A description of the change that caused the adjustment

Amount	The dollar amount of the adjustment
Total Month Capitation	A subtotal of adjustment amounts for each month
Total Retroactive	A total of all retroactive adjustments
Net Capitation	The net capitation amount for all periods
CIN#	A 9 character number for Cin Number
Aid code	A two-position code(either two numbers or a number and a letter), which assist providers in identifying the types of services for which Medi-Cal recipients are eligible.
Aid category	A 3-position code which identifies the Aid category code of a member.
Project code	A 3-position code which identifies the project code of a member.
Medicare part A flag	A one-position flag which indicate if member has Part A coverage(Hospital insurance)
Medicare part B flag	A one-position flag which indicate if member has Part B coverage(Medical insurance)
Medicare part D flag	A one-position flag which indicate if member has Part D coverage(outpatient Prescription Drug insurance)
Aid category Description	A 15 position description that identifies the aid category in which the member belongs.
Capitation Summary	
Total Remittance per categories per month	Total remittances per categories per month.
Total Remittance per product	Total remittances per product.
Grand Total Remittance	Grand Total Remittances.

Member Status Table	
Field Name	**Values**
Medicare Part A Status	Y = Part A N = Part A Equivalent
Medicaid Status	Y = Yes N = No
Member Status	0 = Standard 1 = ESRD 2 = Hospice 3 = Institutionalized
Working Aged	Y = Yes N = No
Medicaid Add-on	Y = Yes N = No
Disabled	Y = Yes N = No
Default Risk Factor	Y = Yes N = No
Dialysis Indicator	Y = Yes N = No

Reopen Request Form for Providers

Health Net complies with the Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Manual, Chapter 13, when a physician or Medicare Advantage (MA) member (or an MA member's authorized representative) requests to reopen a prior authorization of a previously denied organization determination of medical services based on clerical error or the availability of additional information.

In order for Health Net to consider reopening a determination, please fax this form and any additional relevant information to Health Net the following fax numbers as applicable:

- **Arizona:** (800) 840-1097
- **California:** (800) 793-4473
- **Oregon:** (866) 295-8562

Physician Full Name: _____

Physician Identification (ID) #: _____

Physician Telephone Number: _____

Member Name: _____

Member Health Net ID#: _____

Specific reason for your request:

_____

_____

_____

_____

_____

_____

_____

_____

_____

- For reopen requests of previously denied standard determinations, Health Net will respond to your request no later than 30 days after the date of receipt of this form
- For reopen requests of previously denied expedited determinations, Health Net will respond to your request no later than 72 hours after the date of receipt of this form, unless an extension is granted

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! =Report immediately by telephone (designated by a ♦ in regulations).
† =Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ =Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
=All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae,* invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

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* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

PROVIDER ID: M-0123 NAME: SAMPLE MEDICAL GROUP / MONTEREY PARK
012 SOUTH ATLANTIC BLVD. SUITE 000
MONTEREY PARK, CA 012345

INCURRED MONTH	THIS MONTH AMOUNT PAID	THIS MONTH MEMBERS	TO DATE AMOUNT PAID	TO DATE MEMBERS
CATEGORY	BPC - PROFESSIONAL CAPITATION		SPC - MEDICARE HMO	
03/04	0.00	0	11,384.14	34
04/04	0.00	0	11,527.01	34
05/04	0.00	0	11,527.01	34
06/04	0.00	0	11,527.01	34
07/04	0.00	0	11,356.64	33
08/04	0.00	0	11,356.64	33
09/04	0.00	0	11,356.64	33
10/04	0.00	0	11,400.43	33
11/04	0.00	0	11,439.12	33
12/04	0.00	0	11,439.12	33
SUBTOTAL	0.00	0	114,313.76	334
01/05	0.00	0	12,314.58	33
02/05	0.00	0	12,256.08	33
03/05	0.00	0	11,836.08	32
04/05	0.00	0	11,865.83	32
05/05	0.00	0	11,938.51	33
06/05	0.00	0	11,938.51	33
07/05	0.00	0	11,938.51	33
08/05	0.00	0	11,546.42	32
09/05	0.00	0	11,546.42	32
10/05	0.00	0	11,551.26	32
11/05	0.00	0	11,244.13	31
12/05	0.00	0	11,834.97	33
SUBTOTAL	0.00	0	141,811.30	389
01/06	0.02	0	12,831.97	32
02/06	0.00	0	12,071.83	31
03/06	0.00	0	12,084.32	31
04/06	0.00	0	12,084.32	32
05/06	0.00	0	12,889.40	33
06/06	0.00	0	12,654.42	33
07/06	0.00	0	12,981.60	34
08/06	0.00	0	12,981.60	34
09/06	0.00	0	12,981.60	34
10/06	0.00	0	12,750.01	33
11/06	0.00	0	12,750.01	33
12/06	0.00	0	12,750.01	33
SUBTOTAL	0.02	0	151,811.09	393
01/07	0.00	0	14,344.79	34
02/07	0.00	0	14,344.79	34
03/07	14,344.79	34	14,344.79	34
SUBTOTAL	14,344.79	34	43,034.37	102
TOTAL	14,344.81	34	450,970.52	1218

HEALTH NET SB 260 RECONCILIATION REPORT FORM

EXHIBITS I – II

SPC_RPT_BRM_28

Exhibit I - Capitation Category Code Table	
Category Code	Description
California:	
BPC	Professional Capitation
BHC	Hospital Capitation
CHI	Chiropractic Capitation
FFS	Fee-for-Service
NHP	No HCFA Payment

Exhibit II - Capitation Product Code Table	
Product Code	Description
California:	
SPC	Seniority Plus Capitation/HMO
SNP	Seniority Plus Capitation – Special Needs Patients

2010 FINAL MEDICARE PHARMACY SETTLEMENT EXAMPLE

PPA *1998 PLUS*

PARENT PPG NAME: *ABC Medical Group, Inc.*
PARENT PPG #: *1177*
SETTLEMENT PERIOD: *01/2010 THROUGH 12/2010*

			Footnotes:
CONTRACT TERMS			
Is the prescription cost target based on CAB model?		YES	(1)
If not on CAB model:			
A. Target as a % of medicare revenue, or		N/A	(2)
B. Target as a flat per member per month (PMPM):		N/A	(3)
Target prescription cost (PMPM)	$	64.6139	(4)
2010 UNADJUSTED PRESCRIPTION EXPERIENCE			
Total pharmacy prescriptions		21,346	
Unadjusted prescription cost PMPM	$	158.84	
Member months (pharmacy eligible member months)	x	7,028	(5)
Total paid claims	$	1,116,345.63	
Average unadjusted cost per prescription	$	52.30	
2010 PRESCRIPTION COST ADJUSTMENTS			
Injectable medications			
Total injectable medication prescriptions		22	
Average injectable medication cost per prescription	$	857.77	(6)
Total amount paid for injectable medications	$	18,870.92	
Injectable prescription cost PMPM	$	2.69	
2010 ADJUSTED PRESCRIPTION EXPERIENCE			
Adjusted prescriptions		21,324	(7)
Adjusted prescription cost PMPM	$	156.16	
PHARMACY SETTLEMENT (DEFICIT)	$	-321,684.14	(8)
APPLIED SHARING SPLITS AND UPSIDE/DOWNSIDE LIMITS:			
Downside sharing split:		50%	
Downside settlement limit (% of shared risk budget):		N/A	(9)
Downside settlement limit (PMPM):		N/A	
Downside settlement limit (% of commercial professional capitation):		N/A	

PPG Satellites Included in this Settlement: **(10)**

1177 *1178* *1179* *1180* *1694* *1695* *1799* *1909* *5131*

(1) Revenue funding method flags. Options are YES for percent of CMS payment as shown on Addendum C.2; NO for PMPM rate.
(2) If revenue funding method is NO, and Rx budget is a percentage of CMS revenue, than percentage is shown. Currently not applicable.
(3) If revenue funding method is NO, and the Rx budget is a PMPM rate, than the PMPM rate is shown.
(4) If revenue funding method is YES, than PMPM of the percentage of CMS payment as shown on Addendum C.2.
(5) Gross pharmacy data.
(6) Injectable medications are excluded from the pool.
(7) Net pharmacy prescriptions and PMPM.
(8) The settlement/deficit equals the revenue less adjusted prescription cost with the sharing splits applied.
(9) Upside or downside sharing split and settlement limits, if applicable.
(10) The pharmacy is reported on the parent level; this shows the individual satellites that are included.

SHARED RISK PHARMACY SETTLEMENT EXAMPLE

2007 FINAL COMMERCIAL PHARMACY SETTLEMENT
PSA 1998 PLUS
PARENT PPG NAME: ABC Medical Group, Inc.
PARENT PPG #: 1234
SETTLEMENT MONTHS: 01/2007 THROUGH 12/2007

				Footnotes:
CONTRACT TERMS				
Pharmacy Shared Risk Budget (PMPM)		$	15.00	(1)
Demo/Plan Factor	(Not Applicable)			(2)
Adjusted Target Prescription Cost (PMPM)		$	15.00000	(3)
2007 UNADJUSTED PRESCRIPTION EXPERIENCE				
Total Pharmacy Prescriptions			2,092	
Unadjusted Prescription Cost Per Member Per Month (PMPM)		$	25.89	(4)
Member Months (Pharmacy Eligible Member Months)		x	2,975	
Total Paid Claims		$	77,015.60	
Average Unadjusted Cost Per Prescription		$	36.81	
2007 PRESCRIPTION COST ADJUSTMENTS				
HIV Drugs				
Total HIV Drug Prescriptions			12	
Average HIV Drug Cost Per Prescription		$	455.21	
Total Amount Paid for HIV Drugs		$	5,462.50	
HIV Prescription Cost PMPM		$	1.84	(5)
Injectable Drugs				
Total Injectable Drug Prescriptions			2	
Average Injectable Drug Cost Per Prescription		$	121.65	
Total Amount Paid for Injectable Drugs		$	243.30	
Injectable Prescription Cost PMPM		$	0.08	
2007 ADJUSTED PRESCRIPTION EXPERIENCE				
Adjusted Prescriptions			2,078	(6)
Adjusted Prescription Cost PMPM		$	23.96968	
PHARMACY SETTLEMENT (DEFICIT)		$	(13,342.40)	
APPLIED SHARING SPLITS AND UPSIDE/DOWNSIDE LIMITS:				
Downside Sharing Split:			50%	
Downside Settlement Limit (% of Shared Risk Budget): (if applicable)			N/A	(7)
Downside Settlement Limit (PMPM): (if applicable)			N/A	
Downside Settlement Limit (% of Commercial Professional Capitation): (if applicable)			N/A	

PPG Satellites Included in this Settlement:

1234 *456* *789* **(8)**

(1) Shared Risk PMPM as stated in contract.
(2) Age, Sex, and benefit plan adjustment if applicable.
(3) Shared Risk Age, Sex, and benefited adjusted PMPM.
(4) Gross Pharmacy Data.
(5) HIV and Injectable Adjusted.
(6) Net Pharmacy Prescriptions and PMPM.
(7) Upside or Downside Sharing Spilt and Settlement Limits if applicable.
(8) The Pharmacy is reported on the Parent level, this show the individual satellites that are included.

Health Net of California, Inc.
Provider Actuarial

SHARED RISK HMO SETTLEMENT EXAMPLE

STANDARD HMO — 2007 FINAL SHARED RISK SETTLEMENT
PSA 1998 PLUS
SETTLEMENT MONTHS: 01/2007 THROUGH 12/2007
PPG # 1234
ABC Medical Group - Alpha City

				Footnotes:
Gross Shared Risk Revenue PMPM		$	87.40	(1)
Demo/Plan Adjustment		x	1.084547	(2)
Member Months		x	5,849	(3)
Gross Shared Risk Revenue		$	554,423.41	
Less:	Reinsurance Cost (1)	-	80,446.84	
	Transfer Reinsurance Cost (4)	-	0.00	
	Out of Area Service Adjustment (2)	-	1,525.92	
Net Shared Risk Revenue		$	472,450.65	
Less Incurred Claims:				
	Prior Years' Claims Paid 4/2007 - 3/2008	-	30,327.55	
	Current Claims: Claims Incurred 1/2007 - 12/2007, Paid 1/2007 - 12/2007	-	299,701.14	
	Future Claims: Claims Incurred 1/2007 - 12/2007, Paid 1/2008 - 3/2008	-	97,845.84	
	ESRD Claims (If Applicable)	-	0.00	
	Additional Claims	-	0.00	
	Home Infusion/DME Service Adjustment	-	7,135.78	
	Claims over Stop Loss (Deducted from Incurred Claims)	+	0.00	(4)
Net SR Revenue Less Incurred Claims:		$	37,440.34	
PPG's Share of Gain:	50.00% Subject to: 20.00% Capitation Limit (3a)			
PPG's Share of Loss:	50.00% Subject to: 20.00% Capitation Limit (3b)			
Shared Risk Settlement (Deficit)		$	18,720.17	

(1) Reinsurance Cost		=	Gross Shared Risk x Reinsurance Rate			
		=	$554,423.41	x	14.51%	
		=			$80,446.84	
(2) OOA Service Adjustment		=	OOA Service Cost x Adjustment Rate			
		=	$7,629.62	x	20.00%	
		=			$1,525.92	
(3) Settlement Limits	(a) Max Gain:	=	$83,522.19			(5)
	(b) Max Loss:	=	N/A			
(4) Transfer Reinsurance		=	Member Months x PMPM Transfer Reinsurance Rate			
		=	5,849	x	0.00	
		=			$0.00	
(5) Professional Capitation		=	$417,610.93			

(1) Shared Risk PMPM as stated in contract.
(2) Age, Sex, and benefit plan adjustment if applicable.
(3) Member months for the settlement months being reported.
(4) Any claims over the stop loss threshold are added back, usually 80% since 100% of the claim amount is deducted in the incurred claims buckets. By adding the 80% back, the shared risk claims pool is only charged 20% of the claim as indicated in the contract.
(5) Detail calculation of deductions, and Total Professional Capitation for the reporting period.

Health Net of California, Inc.
Provider Actuarial

SHARED RISK POS SETTLEMENT EXAMPLE

SMALL GROUP POS — 2007 FINAL SHARED RISK SETTLEMENT
PSA 1998 PLUS
SETTLEMENT MONTHS: 01/2007 THROUGH 12/2007
PPG # 2345
ABC Medical Group - Zada City

INSTITUTIONAL POOL		PMPM Budget Before Multiplier	x	Institutional Multiplier	=	PMPM Budget After Multiplier	**Footnotes:**
Gross Institutional Shared Risk Revenue PMPM (Before Demo/Plan Adjustment)		72.71		1.100		79.98	**(1)**
Demo/Plan Factor					x	0.710809	**(2)**
Member Months					x	1,308	**(3)**
Gross Institutional Shared Risk Revenue Adjusted for Multplier and Demo/Plan					$	74,360.42	
Less:	Reinsurance Cost (1)				-	11,905.10	
Institutional Shared Risk Revenue					$	62,455.32	
Less Institutional Incurred Claims:	Prior Years' Claims Paid 4/2007 - 3/2008				-	1,730.65	
	Tier 1 Claims Incurred 1/2007 - 12/2007, Paid 1/2007 - 3/2008				-	178,297.88	
	Tier 2 Claims Incurred 1/2007 - 12/2007, Paid 1/2007 - 3/2008				-	5,009.93	
	Tier 3 Claims Incurred 1/2007 - 12/2007, Paid 1/2007 - 3/2008				-	0.00	
	Additional Claims				-	0.00	
	ESRD Claims (If Applicable)				-	0.00	
	Out-of-Area Claims Adjustment (2)				-	73.10	
	Claims over Stop Loss (Deducted from Incurred Claims)				+	0.00	**(4)**
Institutional SR Revenue Less Incurred Claims:					$	(122,656.24)	
PPG's Share of Gain:	50% Subject to:	20% Capitation Limitation					
PPG's Share of Loss:	50% Subject to:	20% Capitation Limitation					
Institutional Shared Risk Settlement (Deficit)					$	(14,284.17)	

PROFESSIONAL POOL				
100% of Professional Capitation	$	71,420.85		**(5)**
Professional Multiplier	x	1.100		**(6)**
100% of the Professional Capitation adjusted by Multiplier	$	78,562.94		**(7)**
Less Upfront Capitation Paid	-	58,922.20		**(8)**
Gross Professional OON Revenue	$		19,640.73	
Less: Transplant Adjustment (4)	-	0.00		
AIDS Adjustment (5)	-	300.84		
OON Professional Stoploss (6)	-	91.56		
Net Professional OON Revenue	$		19,248.33	

Less OON Professional Incurred Claims:	Prior Years' Claims Paid 4/2007 - 3/2008	-	362.12	
	Tier 2 Claims Incurred 1/2007 - 12/2007, Paid 1/2007 - 3/2008	-	5,837.43	
	Tier 3 Claims Incurred 1/2007 - 12/2007, Paid 1/2007 - 3/2008	-	462.00	
	Additional Claims	-	0.00	
	Claims Over Stop Loss (Deducted from Incurred Claims)	+	0.00	**(4)**
Net Professional OON Revenue Less Incurred Claims:		$	12,586.78	
PPG's Share of Gain:	50% Subject to:	100% Capitation Limitation		
Professional OON Shared Risk Settlement (Deficit)		$	6,293.39	

(1) Reinsurance Cost	=	Gross Shared Risk Adjusted for Multiplier x Reinsurance Rate					
	=	$74,360.42	x	16.01%	=	$11,905.10	
(2) OOA Service Adjustment	=	Out-Of-Area Service Cost x Adjustment Rate					
	=	$365.50	x	20.00%	=	73.10	
(3) Gross Capitation Available	=	Paid Cap / Percent of Cap Upfront - Paid Cap					
			less	Aids and Trans Out of Cap			
	=	$58,922.20	/	82.50%	-	$58,922.20	
			less	$863.28			**(9)**
	=	$11,635.37					
(4) Transplant Adjustment	=	Transplant Rate (for OON Revenue) x Member-Months					
	=	$0.00	x	1,308	=	$0.00	
(5) AIDS Adjustment	=	AIDS Rate (for OON Revenue) x Member-Months					
	=	$0.23	x	1,308	=	$300.84	
(6) OON Professional Stoploss	=	OON Prof. Rate x Member-Months					
	=	$0.07	x	1,308	=	$91.56	

(1) Shared Risk PMPM as stated in contract.
(2) Age, Sex, and benefit plan adjustment if applicable.
(3) Member months for the settlement months being reported.
(4) Any claims over the stop loss threshold are added back, usually 80% since 100% of the claim amount is deducted in the incurred claims buckets. By adding the 80% back, the shared risk claims pool is only charged 20% of the claim as indicated in the contract.
(5) Net POS Capitation paid to PPG after deducting withhold.
(6) Professional POS multiplier.
(7) Gross POS Capitation before withhold.
(8) 82.5% to bring withhold to equal 17.5% of Small Group POS Professional POS capitation.
(9) Detail calculation of deductions.

Health Net of California, Inc.
Provider Actuarial

SHARED RISK MEDICARE SETTLEMENT EXAMPLE

MEDICARE HMO 2007 FINAL SHARED RISK SETTLEMENT
PSA 1998 PLUS
SETTLEMENT MONTHS: 01/2007 THROUGH 12/2007
PPG # 456
ABC Medical Group - Alpha City

					Footnotes:
Member Months				163	(1)
Shared Risk Revenue as a Percent of Premium				43.88%	(2)
Applicable Medical Revenue	(Gross Revenue Model)		x	159,214.24	(3)
Gross Shared Risk Revenue			$	69,863.21	(4)
Less:	Reinsurance Cost (1)		-	3,582.32	
	Out-of-Area Service Adjustment (2)		-	0.00	
Net Shared Risk Revenue			$	66,280.89	
Less Incurred Claims:					
	Prior Years' Claims Paid 4/2007 - 3/2008		-	(627.97)	
	Current Claims: Claims Incurred 1/2007 - 1/2007, Paid 1/2007 - 12/2007		-	84,410.49	
	Future Claims: Claims Incurred 1/2007 - 1/2007, Paid 1/2008 - 3/2008		-	653.09	
	Additional Claims		-	0.00	
	Home infusion/DME Service Adjustment		-	1,670.75	
	ESRD Claims (if applicable)		-	0.00	
	Claims over Stop Loss (Deducted from Incurred Claims)		+	0.00	(5)
Net SR Revenue Less Incurred Claims:			$	(19,825.47)	
	PPG's Share of Gain:	50% Subject to:	20% Capitation Limit (3a)		
	PPG's Share of Loss:	50% Subject to:	20% Capitation Limit (3b)		
Shared Risk Settlement (Deficit):			$	(9,912.74)	

(1) Reinsurance Cost		=	Gross Medical Revenue x Reinsurance Rate			
		=	$159,214.22	x	2.25%	
		=			$3,582.32	
(2) OOA Service Adjustment		=	OOA Service Cost x Adjustment Rate			
		=	$0.00	x	20.00%	
		=			$0.00	(6)
(3) Settlement Limits	(a) Max Gain:	=	N/A			
	(b) Max Loss:	=	($12,074.16)			
(4) Professional Capitation		=	$60,370.80			

(1) Member months for the settlement months being reported.
(2) Shared Risk Budget as a percentage of Medicare Revenue.
(3) Medicare Revenue received from CMS
(4) Net Shared Risk Revenue
(5) Any claims over the stop loss threshold are added back, usually 80% since 100% of the claim amount is deducted in the incurred claims buckets. By adding the 80% back, the shared risk claims pool is only charged 20% of the claim as indicated in the contract.
(6) Detail calculation of deductions, and Total Professional Capitation for the reporting period.

Health Net of California, Inc.
Provider Actuarial

health net
Post Office Box 10344
Van Nuys, California 91410-0344

MEDICARE ADVANTAGE TRANSFER / TERMINATION INCIDENT REPORT

First	MI	Health Net Identification #
PPG / IPA Name		PPG / IPA #
Counselor:		Date

INCIDENT REPORT DATES / TYPE

1st INCIDENT DATE	LEVEL	☐ **A**	☐ **B**	☐ **C**
2nd INCIDENT DATE	LEVEL	☐ **A**	☐ **B**	☐ **C**
3rd INCIDENT DATE	LEVEL	☐ **A**	☐ **B**	☐ **C**

DESCRIPTION OF INCIDENTS

DATE OF LETTER TO MEMBER FOLLOWING COUNSELING SESSION	ATTACH COPY OF LETTER, RECOMMEND LETTER BE SENT BY REGISTERD MAIL, RETURN RECEPT REQUEST

DOCUMENTATION OF COUNSELING OF PATIENT REGARDING INCIDENT. (IF COUSELING DOCUMENTED IN THE MEDICAL RECORD BY PHYSICIAN, PA, RNP ATTACH COPY OF DOCUMENTATION)

FOR HEALTH NET USE ONLY

DATE REPORT RECEIVED FROM PMG: * WITNESS REPORT REQUIRED	DATE OF WARNING LETTER TO MEMBER:	COMMENTS:

Transitions of Care Management (TRC) Worksheet

Patient Name: _____ DOB: ____/____/____ Member ID: _____

Discharge Facility: _____ Admit Date: ____/____/____ Discharge Date: ____/____/____

PCP or Ongoing Care Provider Name: _____

Transitions of Care – Notification of Inpatient Admission (TRC-NIA)

Date of Admission Notification: _____/_____/_____
Method of Notification:

☐ Phone ☐ Email/Fax ☐ Shared EMR ☐ ADT Feed ☐ HN Provider Portal ☐ HIE Portal

☐ Provider performed a preadmission exam (not pre-op exam) or received notification of a planned admission prior to the admit date.

☐ Other: _____

TRC - Notification of Inpatient Admission: No Administrative Codes available-documentation review required.

Transitions of Care – Receipt of Discharge Information (TRC-RDI)

Date of Receipt of Discharge: _____/_____/_____ (includes the day of discharge through 2 days post discharge) TRC-RDI

Method of Notification:

☐ Phone ☐ Email/Fax ☐ Shared EMR ☐ ADT Feed ☐ HN Provider Portal ☐ HIE Portal ☐ Other: _____

Discharge Summary Included: ☐ Yes ☐ No

If discharge summary is not included, complete all information below:

The practitioner responsible for the member's care during the inpatient stay: _____

Procedures of treatment provided: _____

Diagnosis at discharge: _____

Current medication list: _____

Testing results, or documentation of pending tests or no tests pending: _____

Instructions for patient care post-discharge: _____

TRC - Receipt of Discharge Information: No Administrative Codes available - documentation review required.

Transitions of Care – Patient Engagement (TRC-PE)
Please use this as a guide to submit the appropriate codes for services completed.

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Outpatient Visits If YES, date: _____/_____/_____

CPT Codes Submitted (99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347-99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483): ☐ Yes ☐ No

HCPCS Codes Submitted (G0402, G0438, G0439, G0463, T1015): ☐ Yes ☐ No

Telephone Visits

CPT Codes Submitted (98966-98968, 99441-99443): ☐ Yes ☐ No

Online Assessment (e-visit/virtual check-in)

CPT Codes Submitted (98969-98972, 98980, 98981, 99421-99423, 99444, 99457, 99458: ☐ Yes ☐ No

HCPCS Codes Submitted (G0071, G2010, G2012, G2061-G2063, G2250-G2252): ☐ Yes ☐ No

(continued)

Administrative codes for MRP
Please use this as a guide to submit the appropriate codes for services completed.

CPT Codes Submitted (99483, 99495, 99496): ☐ Yes ☐ No
CPT CAT II Code Submitted (1111F): ☐ Yes ☐ No

**If Other, Please Explain: _____

Do you need help?

☐ No
☐ Submitting CPT/CPTII codes
☐ Member with frequent readmissions
☐ Documentation review
☐ Contacting members
☐ MPR completed and in member's file.

If unable to submit CPT or CPTII code: **Complete the MRP form on the last page.**

Medication Reconciliation Post-Discharge provider assessment (MRP)

Please use this assessment form to help provide correct documentation needed to close the Medication Reconciliation Post-Discharge (MRP) Healthcare Effectiveness Data and Information Set (HEDIS) measure. Medication reconciliation needs to be completed on the date of discharge through 30 days after discharge (31 days total). After completion, place a copy of the completed form in the patient's record.

Member information

Patient Name: _____ DOB: ____/____/____ Member ID: _____

Medication Reconciliation Date: ____/____/____ Post-Discharge Hospital Follow-Up Visit: ☐ Yes ☐ No

Discharge information

Discharge Date: ____/____/____

Admission Diagnosis: _____

Diagnosis Discharge: _____

Facility: _____ Hospitalist: _____

List of medications current and discharge
Document all prescriptions, over-the-counter and herbal supplements below.

Date Reviewed: ____/____/____

☐ Patient was not prescribed any medications upon discharge.
☐ Patient's discharge and current medication list is attached.

Drug name	Dose at discharge	Frequency

Provider Name (Print): _____

Credentials: ☐ RN ☐ MD ☐ DO ☐ NP/APRN ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____ Date: ____/____/____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.
If medications were reconciled during office visit, or if this form is completed, please submit Code 1111F to the health plan to capture compliance.

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23-1222/FRM1323151EC01w (12/23)

HEALTH NET
TRANSPLANTATION REQUEST
BMT/PBSCT

Patient: _____ Age: _____ Date: _____

Member #: _____

Transplant Type

Autologous: _____ Allogenic: _____

HLA Related: Antigen Match: ___/6
HLA Unrelated: Antigen Match: ___/6

Stem Cell Source

Stem Cell: _____
Blood: _____
Umbilical Cord: _____

Disease Type: _____

Transplant Center Attending Physician: _____

Phone: _____
Fax: _____

Form Completed By: _____

Title: _____
Phone: _____
Fax: _____

TRANSPLANT CENTER ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
_
Signature

_____
Date

HEALTH NET
TRANSPLANTATION REQUEST
BMT/PBSCT

PATIENT CLINICAL PROFILE

CLINICAL HISTORY

Date of Diagnosis: _____

Disease Stage at Diagnosis: _____

How Documented: _____

High Risk Factors:

_____

_____

Initial Treatment Modalities:

Radiation: No:_____ Yes: _____ Date: _____

Clinical Response: _____

How Documented: _____

Chemotherapy: No:_____ Yes: _____ Date: _____

Agents: _____

Clinical Response: _____

How Documented: _____

Other: _____ Date: _____

Clinical Response: _____

How Documented: _____

Date of Documented Relapse: _____

Disease Stage at Relapse: _____

Follow-up Treatment Modalities: _____

Type: _____

Clinical Response: _____

HEALTH NET
TRANSPLANTATION REQUEST
BMT/PBSCT

How Documented: _____

Present Disease Stage: _____

Date of Recent Stem Cell Bx: _____

Results of Bx: _____

_____

OTHER MEDICAL FACTORS

Does the patient have?	YES	NO	DOCUMENTATION
Cardiac Dysfunction	_____	_____	_____
Renal Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hepatitis B

Antigen	Positive:	_____	Negative:	_____
Antibody	Positive:	_____	Negative:	_____

Hepatitis C

Antigen	Positive:	_____	Negative:	_____
Antibody	Positive:	_____	Negative:	_____

HIV	Positive	_____	Negative:	_____
AIDS?	Yes	_____		
	No	_____		

HEALTH NET
TRANSPLANTATION REQUEST
BMT/PBSCT

Psychosocial background, including history of alcohol or drug abuse:

_____

_____

_____

_____

Other Comments:

_____

_____

_____

_____

HEALTH NET
TRANSPLANTATION REQUEST
HEART

Patient:_____ Age:_____ Date: _____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure: _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax: _____

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

HEALTH NET
TRANSPLANTATION REQUEST
HEART

PATIENT CLINICAL PROFILE

CLINICAL HISTORY (Functional Assessment Over Time)

_____

_____

_____

PATIENT'S NEW YORK HEART ASSOCIATION FUNCTIONAL CLASSIFICATION

Present _____ 1 Year Ago _____

6 months ago _____ 2 Years Ago _____

DOCUMENTATION OF END-STAGE HEART DISEASE

Medications (dose/response) during the past 24 months

_____

_____

_____

Present Medications (dose/response)

_____

_____

_____

Cardiac Cath Result **Date of Cath** _____

Ejection fraction: _____

PCW pressure: _____

PA pressure: _____

RV pressure: _____

HEALTH NET
TRANSPLANTATION REQUEST
HEART

DOCUMENTATION OF END-STAGE HEART DISEASE (CONT.)

Cardiac Cath Result (Cont.)

Coronary anatomy: _____

Chamber/septal anatomy: _____

- What is the pulmonary vascular resistance (Woods Units) _____
- Has the patient had inotropes/vasodilators with a remeasuring of the pulmonary vascular resistance?

YES _____ NO _____

RESULT (Woods Units) _____

OTHER MEDICAL FACTORS

Does the patient have?

	YES	NO	DOCUMENTATION
Renal Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Cerebrovascular Disease	_____	_____	_____
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

HEALTH NET
TRANSPLANTATION REQUEST
HEART

LAB TESTS

Hepatitis B					
	Antigen	Positive:	_____	Negative:	_____
	Antibody	Positive:	_____	Negative:	_____
HIV		Positive	_____	Negative:	_____

Psychosocial background, including history of alcohol or drug abuse:

_____

_____

_____

Other Comments:

_____

_____

_____

HEALTH NET
TRANSPLANTATION REQUEST
HEART/LUNG

Patient:_____ Age:_____ Date: _____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax: _____

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

HEALTH NET
TRANSPLANTATION REQUEST
HEART/LUNG

PATIENT CLINICAL PROFILE

CLINICAL HISTORY (FUNCTIONAL ASSESSMENT OVER TIME)

_____

_____

_____

PATIENT'S NEW YORK HEART ASSOCIATION FUNCTIONAL CLASSIFICATION

Present _____ 1 Year Ago _____

6 months ago _____ 2 Years Ago _____

DOCUMENTATION OF END-STAGE CARDIAC/LUNG DISEASE

Medications (dose/response) during the past 24 months

_____

_____

_____

Present Medications (dose/response)

_____

_____

_____

Cardiac Cath Result **Date of Cath _____**

Ejection fraction: _____

PCW pressure: _____

PA pressure: _____

RV pressure: _____

Coronary anatomy: _____

Chamber/septal anatomy: _____

HEALTH NET
TRANSPLANTATION REQUEST
HEART/LUNG

DOCUMENTATION OF END-STAGE CARDIAC/LUNG DISEASE (CONT.)

- What is the pulmonary vascular resistance (Woods Units) _____
- Has the patient had inotropes/vasodilators with a remeasuring of the pulmonary vascular resistance?

  YES _____ NO _____

  RESULT (Woods Units) _____

PFT RESULT

Date of PFT _____

		Without Bronchodilators (% Predicted)	With Bronchodilators (% Predicted)
FVC	(forced vital capacity)	_____	_____
FEV1	(forced expiratory volume)	_____	_____
PEFR	(peak expiratory flow rate)	_____	_____
MVV	(maximum voluntary ventilation)	_____	_____
TLC	(total lung capacity)	_____	_____
FRC	(functional residual capacity)	_____	_____
RV	(residual volume)	_____	_____
ABG	(room air)	_____	_____

Does the patient smoke? Yes _____ No _____

OTHER MEDICAL FACTORS

Does the patient have?

	YES	NO	DOCUMENTATION
Renal Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____

HEALTH NET
TRANSPLANTATION REQUEST
HEART/LUNG

OTHER MEDICAL FACTORS (CONT.)

	YES	NO	DOCUMENTATION
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hepatitis B
- Antigen — Positive: _____ Negative: _____
- Antibody — Positive: _____ Negative: _____

HIV — Positive _____ Negative: _____

Psychosocial background, including history of alcohol or drug abuse:

_____

_____

_____

Other Comments:

_____

_____

_____

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY

Patient:_____ Age:_____ Date: _____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure: _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax: _____

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY

PATIENT CLINICAL PROFILE

CLINICAL HISTORY

_____

_____

_____

DOCUMENTATION OF END-STAGE KIDNEY DISEASE

Treatment during the past 24 months (date of initial dialysis, if applicable)

_____

_____

_____

Present Treatment

_____

_____

_____

Kidney biopsy result _____

Kidney function tests Result

BUN	_____
Creat	_____
Na+	_____
K+	_____
Cl-	_____
HCO3-	_____

Abdominal ultrasound result _____

CAT scan result _____

Arteriogram result _____

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY

Thallium treadmill result _____

Cardiac cath result _____

OTHER MEDICAL FACTORS

Does the patient have?	YES	NO	DOCUMENTATION
Cardiac Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Cerebrovascular Disease	_____	_____	_____
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hepatitis B
- Antigen Positive: _____ Negative: _____
- Antibody Positive: _____ Negative: _____

HIV Positive _____ Negative: _____

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY

Psychosocial background, including history of alcohol or drug abuse:

_____

_____

_____

Other Comments:

_____

_____

_____

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY/PANCREAS

Patient:_____ Age:_____ Date: _____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure: _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax: _____

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY/PANCREAS

PATIENT CLINICAL PROFILE

CLINICAL HISTORY

_____

_____

_____

DOCUMENTATION OF END-STAGE PANCREATIC DISEASE

Medications (dose/response) during the past 24 months

_____

_____

_____

Present Medications (dose/response)

_____

_____

_____

Diabetic Complications

	YES	NO	DOCUMENTATION
Renal Failure	_____	_____	_____
Retinopathy	_____	_____	_____
Neuropathy	_____	_____	_____
Cardiovascular	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Neurovascular Disease	_____	_____	_____

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY/PANCREAS

Does the patient have insulin resistance? Yes _____ No _____

What is the patient's blood pressure? _____

DOCUMENTATION OF END-STAGE PANCREATIC DISEASE (CONT.)

Has the patient had?

	YES	NO	RESULT
Thallium Treadmill	____	____	_____
Coronary Angiogram	____	____	_____

OTHER MEDICAL FACTORS

Does the patient have?

	YES	NO	DOCUMENTATION
Cardiac Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hob A1C Current: _____ 6 mos. ago: _____ 1 yr. ago: _____

Hepatitis B
Antigen Positive: _____ Negative: _____

Antibody Positive: _____ Negative: _____

HIV Positive: _____ Negative: _____

HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY/PANCREAS

Psychosocial background, including history of alcohol or drug abuse:

_____

_____

_____

Other Comments:

_____

_____

_____

HEALTH NET TRANSPLANTATION REQUEST-LIVER

11/97

HEALTH NET
TRANSPLANTATION REQUEST
Liver

Patient: _____ Age:_____ Date:_____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure: _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax: _____

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

11/97

HEALTH NET
TRANSPLANTATION REQUEST
Liver

PATIENT CLINICAL PROFILE

CLINICAL HISTORY

_____

_____

_____

DOCUMENTATION OF END-STAGE LIVER DISEASE

Medications (dose/response) during the past 24 months

_____

_____

_____

Present medications (dose/response)

_____

_____

_____

Liver biopsy result _____

Liver function tests	Result	Normal Range
SGOT	_____	_____
SGPT	_____	_____
LDH	_____	_____
Bilirubin	_____	_____
Alk phos	_____	_____
Albumin	_____	_____
PT	_____	_____

Abdominal ultrasound result _____

CAT scan result _____

Doppler of portal vein result _____

11/97

HEALTH NET
TRANSPLANTATION REQUEST
Liver

DOCUMENTATION OF END-STAGE LIVER DISEASE (cont.)

Arteriogram result _____

Is portal vein patent? Yes _____ No _____

Any evidence of extrabiliary disease? Yes _____ No _____

Describe: _____

_____

OTHER MEDICAL FACTORS

Does the patient have?

	YES	NO	DOCUMENTATION
Cardiac Dysfunction	_____	_____	_____
Renal Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Cerebrovascular Disease	_____	_____	_____
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hepatitis B
- Antigen — Positive: _____ Negative: _____
- Antibody — Positive: _____ Negative: _____

Hepatits C — Positive: _____ Negative: _____
- Antibody — Positive: _____ Negative: _____

HIV — Positive: _____ Negative: _____

HEALTH NET
TRANSPLANTATION REQUEST
Liver

Psychosocial background, including history of alcohol or drug abuse:

_____

_____

_____

For ETOH induced cirrhosis

- How long has the patient been abstinent? _____
- How documented?

  _____

  _____

  _____

- Has patient been in alcohol rehab? Yes _____ No _____

  Describe:

  _____

  _____

  _____

HEALTH NET
TRANSPLANTATION REQUEST
LUNG

Patient:_____ Age:_____ Date: _____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure: _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax:

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

HEALTH NET
TRANSPLANTATION REQUEST
LUNG

PATIENT CLINICAL PROFILE

CLINICAL HISTORY (FUNCTIONAL ASSESSMENT OVER TIME)

_____

_____

_____

DOCUMENTATION OF PULMONARY DISEASE

Medications (dose/response) during the past 24 months

_____

_____

_____

Present Medications (dose/response)

_____

_____

_____

PFT RESULT

Date of PFT _____

		Without Bronchodilators (% predicted)	With Bronchodilators (% predicted)
FVC	(forced vital capacity)	_____	_____
FEV1	(forced expiratory volume)	_____	_____
PEFR	(peak expiratory flow rate)	_____	_____
MVV	(maximum voluntary ventilation)	_____	_____
TLC	(total lung capacity)	_____	_____

HEALTH NET
TRANSPLANTATION REQUEST
LUNG

PFT RESULTS CONTROL

FRC (functional residual capacity) _____ _____

RV (residual volume) _____ _____

ABG (room air) _____ _____

Does the patient smoke? Yes _____ No _____

OTHER MEDICAL FACTORS

Does the patient have?

	YES	NO	DOCUMENTATION
Cardiac Dysfunction	_____	_____	_____
Renal Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hepatitis B
Antigen Positive: _____ Negative: _____

Antibody Positive: _____ Negative: _____

HIV Positive: _____ Negative: _____

HEALTH NET
TRANSPLANTATION REQUEST
LUNG

Psychosocial background, including history of alcohol or drug abuse:

Other Comments:

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
California Pacific Medical Center - San Francisco	**Kidney**	Adult	X	X	X	X*	Enhanced Care PPO utilizes OptumHealth Transplant Network
	Kidney-Pancreas	Adult	X	X	X	X	
	Liver	Adult	X	X	X	X	
	Pancreas	Adult	X	X	X	X	
	Liver-Kidney	Adult	X	X	X	X	
	Heart	Adult	X	X	X	X	
Cedars-Sinai Medical Center - Los Angeles	**Heart**	Adult	X		X		
	Kidney	Adult	X		X		
	Liver	Adult	X		X		
	Stem Cell	Adult	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Children's Hospital and Research Ctr at Oakland "Publicly know as UCSF Benioff Children's Hospital Oakland"	**Stem Cell**	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related	X		X		
Children's Hospital of Los Angeles	**Heart**	Pediatric	X		X		
	Liver	Pediatric	X		X		
	Kidney	Pediatric	X		X		
	Stem Cell	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Children's Hospital of Orange County - Orange	**Stem Cell**	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Loma Linda University Medical Center - Loma Linda	**Heart**	Pediatric	X	X	X		
	Kidney	Adult	X	X	X		
		Pediatric	X	X	X		
	Kidney-Pancreas	Adult	X	X	X		
		Pediatric	X	X	X		
	Liver	Adult	X	X	X		
		Pediatric	X	X	X		
	Pancreas	Adult	X	X	X		
		Pediatric	X	X	X		
Lucile Packard Children's Hospital	**Heart**	Pediatric	X		X	X	
	Heart-Lung	Pediatric	X		X	X	
	Kidney	Pediatric	X		X	X	
	Kidney-Pancreas	Pediatric				X	
	Liver	Pediatric	X		X	X	
	Lung	Pediatric	X		X	X	
	Pancreas	Pediatric				X	
	Stem Cell	Pediatric	X		X	X	
		Autologus Allogeneic Related & Unrelated	X		X	X	
		Allogeneic Related & Unrelated	X		X	X	
Rady Childrens Hospital	**Kidney**	Pediatric	X		X		
	Stem Cell	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Scripps Health - San Diego	**Kidney**	Adult	X	X	X		
	Liver	Adult	X	X	X		
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		

Updated 1/27/2022

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
Sharp Healthcare System	**Heart**	Adult	X	X	X	X	Enhanced Care PPO utilizes OptumHealth Transplant Network
	Kidney	Adult	X		X	X	
Stanford University Hospital - Palo Alto	**Heart**	Adult	X	X	X	X	
	Heart-Lung	Adult	X	X	X	X	
	Kidney	Adult	X	X	X	X	
	Kidney-Pancreas	Adult	X	X	X	X	
	Liver	Adult	X	X	X	X	
	Lung	Adult	X	X	X	X	
	Pancreas after Kidney TP	Adult	X	X	X	X	
	Stem Cell	Adult	X	X	X	X	
		Autologous	X	X	X	X	
		Allogeneic Related & Unrelated	X	X	X	X	
Sutter Medical Center Sacramento	**Heart**	Adult	X	X	X	X	
	Stem Cell	Adult Allogeneic	X	X	X	X	
		Adult Autologous	X	X	X	X	
UC Davis - Sacramento	**Kidney**	Adult Cadaveric & Adult	X	X	X	X	
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		
UC San Diego - San Diego	**Kidney**	Adult	X	X	X	X	
	Heart	Adult	X	X	X		
	Liver	Adult	X	X	X		
	Lung	Adult	X	X	X		
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		
UCSF - SAN FRANCISCO	**Heart**	Adult	X	X	X		
		Pediatric	X		X		
	***Heart-Lung**	Adult	*	**	*		
		Pediatric	*		*		
	Kidney	Adult	X	X	X		
		Pediatric	X		X		
	Kidney-Pancreas	Adult	X	X	X		
	Liver	Pediatric	X		X		
		Adult	X	X	X		
	Lung	Adult	X	X	X		
	Pancreas	Adult	X	X	X		
	***Pancreas Autologous Islet Cell**	Adult	*	**	*		
	Stem Cell	Adult	X	X	X		
		Pediatric	X		X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
Ronald Reagan UCLA Medical Center.	**Heart**	Adult	X		X		Enhanced Care PPO utilizes OptumHealth Transplant Network
		Pediatric	X		X		
	Kidney	Adult	X		X		
		Pediatric	X		X		
	Kidney-Pancreas	Adult	X		X		
	Liver	Adult	X		X		
		Pediatric	X		X		
	Lung	Adult	X		X		
	Pancreas	Adult	X		X		
	Small Bowel	Adult	X		X		
		Pediatric	X		X		
	Stem Cell	Adult	X		X		
		Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
	Liver-Kidney	Adult	X		X		
		Pediatric	X		X		
Keck Hospital of USC.	**Heart**	Adult	X		X		
	Heart-Lung	Adult	X		X		
	Kidney	Adult	X		X		
	Liver	Adult	X		X		
	Lung	Adult	X		X		
	Kidney-Pancreas	Adult	X		X		
	Stem Cell	Adult	X		X		

Updated 1.27.22

X = Participating and Blank = Non Par

*	Transplant is individually negotiated by Letter of Agreement
**	Medicare LOB- Transplant is individually negotiated by Letter of Agreement
***	Medi-Cal LOB- Transplant is individually negotiated by Letter of Agreement

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING HOME HEALTH SERVICES

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for home health services regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used.

SERVICES TO BE PROVIDED
1. Type of services (for example, wound care, teaching, infusion):
2. Frequency of services:
3. How many visits are being requested?
4. How many visits have already been performed?
5. a. Start date of service: b. Anticipated completion date of services:

WOUND CARE
6. Current size of wound: Length_____Width_____Depth _____ Type_____ Amount of drainage_____

7. Type of wound care being performed:
8. Date and type of surgery or description of etiology of wound (for example, diabetic ulcer):

HOME INFUSION
9. Type of medication:
10. Frequency of services:
11. Is medication also being requested or is this request just for nursing? If medication is also being requested, please attach documentation describing patient's clinical diagnosis and medical records supporting the diagnosis, including applicable lab data.

HOME IV THERAPY
12. Type of medication:
13. Frequency of dosing:
14. Describe family/patient's ability/inability to self administer:
15. Diagnosis:

HOME HEALTH TEACHING
16. Document teaching needs, date teaching has been performed, and patient/family response to teaching:

ADDITIONAL QUESTIONS
17. Other services, please describe:
18. When will patient be independent in care? What steps are being taken to discharge from service and when is discharge anticipated?

Please attach physician’s order and documentation confirming homebound status and any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification may be oral and/or electronic)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Pre-Service Organization Determination	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request *Extensions* • May extend up to 14 calendar days. • If extended, the decision is required within a maximum of 28 calendar days after receipt of request • ***Note:*** Extension allowed ***only*** if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny)	Practitioner: Within 14 calendar days after receipt of request or no later than upon expiration of extension (for approvals and denials) *Extensions* Practitioner & Member: When the timeframe is extended, give notice **in writing** of the reasons for the delay, and the right to file a grievance if they disagree with the decision to grant an extension (within 14 calendar days of receipt of request)	Within 14 calendar days after receipt of request *Extensions* Maximum of 28 calendar days after receipt of request if an extension was warranted
Expedited Initial Organization Determination (*see footnote)	Within 72 hours after receipt of request (includes weekends & holidays) • Promptly decide whether to expedite – determine if applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function If submitted as expedited but determined not to be expedited, then pre-service organization determination timeframe applies	Practitioner & Member: Within 72 hours after receipt of request or no later than upon expiration of extension (for approvals and denials) Practitioner & Member: If request is not deemed to be expedited, give prompt oral notice of the	Within 72 hours after receipt of request ▪ ***Note:*** Oral notification to be followed by written notification within 3 calendar days of oral notification **(for approvals and denials)** If request is not deemed to be expedited, follow up written notification to be delivered to the member within 3 calendar

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

ICE CMS UM TAT Final 12-02-02
Revised 6/5/03; 6/20/03; 5/17/04; 7/14/04

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification may be oral and/or electronic)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	• Automatically transfer the request to the standard timeframe • The 14 day period begins with the day the request was received for an expedited determination *Extensions* • May extend up to 14 calendar days. • If extended, the decision is required within a maximum of 17 calendar days after receipt of request • ***Note:*** Extension allowed ***only*** if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny)	denial to expedite the request *Extensions* Practitioner & Member: When the timeframe is extended, give notice **in writing** of the reasons for the delay, and the right to file a grievance if they disagree with the decision to grant an extension (within 72 hours of receipt of request)	days of oral notification *Extensions* Maximum of 17 calendar days after receipt of request if an extension was warranted
Discontinuation of Acute Inpatient Services - Notice of Discharge & Medicare Appeal Rights (NODMAR) (Concurrent)	• Continue coverage of inpatient care until attending physician concurs with discharge	Attending Physician responsible for member's hospital care & must concur before issuance of NODMAR.	Required only if the member disagrees with the discharge decision; or the hospital is not discharging the member but the Health Plan or delegate will no longer continue coverage of the inpatient hospital stay. ▪ The notice must be issued no later than the day before hospital coverage ends. An enrollee is entitled to coverage until at least noon of the day after such notice is provided.

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

ICE CMS UM TAT Final 12-02-02
Revised 6/5/03; 6/20/03; 5/17/04; 7/14/04

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification may be oral and/or electronic)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
			• Obtain acknowledgement of receipt from member, member's representative, or witness of member's refusal to sign
Post-service Organization Determination (Retrospective) Note: Requests for payment that occur through claims follow separate claims processing timeframes.	Within 14 calendar days after receipt of request *<u>Extensions</u>* • May extend up to 14 calendar days • If extended, the decision is required within a maximum of 28 calendar days after receipt of request • ***<u>Note</u>:*** Extension allowed ***only*** if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny)	<u>Practitioner:</u> Within 14 calendar days after receipt of request or no later than upon expiration of extension (for approvals and denials) *<u>Extensions</u>* <u>Practitioner & Member:</u> When the timeframe is extended, give notice **in writing** of the reasons for the delay, and the right to file a grievance if they disagree with the decision to grant an extension (within 14 calendar days of receipt of request)	Within 14 calendar days after receipt of request *<u>Extensions</u>* Maximum of 28 calendar days after receipt of request if an extension was needed

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Notice of Medicare Non-Coverage (NOMNC) Notification**	**Detailed Explanation of Non-Coverage (DENC) Notification**
Termination of Provider Services: • Skilled Nursing Facility (SNF) • Home Health Agency (HHA) • Comprehensive Outpatient Rehabilitation Facility (CORF)	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: • Discharge from SNF, HHA or CORF services **OR** • A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative • The NOMNC must be delivered no later than two (2) calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date and date that coverage of services ends • The NOMNC may be delivered earlier if the date that coverage will end is known <u>*Note*</u>: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: • The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day before the QIO needs to make its decision

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

Weekly Inpatient Denial Log Sheet

Member Name	ID Number	DOB	Admit Date	DC Date	Attending MD/PCP	Facility	ICD -9 Code	Total # Days Authorized	Dates Authorized	# Days Denied	Dates Denied	Reason For Denial	LOC Denied	MD Authorizing Denial	PPG Tracking Number	Comments

DOB – Date of Birth DC Date – Discharge Date LOC – Level Of Care

MD - Medical Doctor PCP –Primary Care Physician PPG – Participating Physician Group

Fax to (818) 676-7304 or
Submit via encrypted email to provider.oversight@healthnet.com or
Mail to Health Net, Hospital Notification Unit, 21281 Burbank Blvd, 5th Floor, Woodland Hills, CA 91367

10/07/2005