Provider Manual - Combined

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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.

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

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 (standard pre-service), 72 hours (expedited request) 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 (standard pre-service), 24 hours (expedited request) 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 for standard or 72 hours for expedited after the date the organization receives the request for a standard or expedited 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 65 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 for a standard request, and no later than 72 hours from the date of the request for an expedited 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 65-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 by participating physicians within 60 calendar days of the date of the written denial notice.

Non-participating physicians are required to submit appeals within 65 calendar days of the date of the written denial notice. Refer to the Non-Contracted Provider Appeals section for additional information.

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). For an expedited 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 72 hours 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.

Participating physicians must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination, except in the case of an extension of the filing time frame. 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.

Non-participating physicians must file the request for reconsideration within 65 calendar days from the date of the notice of the organization determination, Additionally, Health Net informs the non-participating physician 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

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

Provider Disputes

The plan's provider dispute resolution process ensures correct routing and timely consideration of provider disputes. 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 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.

Provider Appeal Procedures

The plan does not charge providers who submit appeals to the Provider Services Center for processing 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.

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)

Dispute a participating physician group’s (PPG’s) written determination following its dispute resolution process when the dispute involves an underpayment of the Medicare Fee Schedule within 180 days from the notice issued by the 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.

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.

Non-contracted Provider Appeals

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

Health Net is a Medicare Advantage organization and as such, is regulated by the Centers for Medicare & Medicaid Services (CMS). In accordance with CMS regulations, providers who are not contracted with a Medicare Advantage organization may file a standard appeal for a claim that has been denied, in whole or in part, but only if they submit a completed Waiver of Liability Statement (PDF). If you complete a Waiver of Liability Statement, you waive the right to collect payment from the member, with the exception of any applicable cost sharing, regardless of the determination made on the appeal.

If you appeal and we uphold the denial, in whole or in part, you will have additional appeal rights available to you including, but not limited to, reconsideration by a CMS contracted independent review entity.

To appeal, mail your request and completed Waiver of Liability Statement (PDF) within 65 calendar days after the date of the Notice of Denial of Payment by either the Plan or the PPG, to Wellcare By Health Net - Appeals.

Non-contracted provider appeal includes:

- 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.
- Challenge PPG or hospital liability decision to pay for a different service or level than billed. Some other reasons for payment appeals are:
    - Bundling issues
    - Diagnosis related group (DRG) payments
    - Downcoding.
- Challenge PPG or hospital liability denial of service(s).
- Challenge capitation deductions that are the result of the plan decisions arising from member billings, claims or member eligibility determinations.

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.

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

B

C

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

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

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

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)

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

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 | Ancillary| Participating Physician Groups (PPG)

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

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

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.

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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

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

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

Home Health Care Services

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

The following are additional components of home health care:

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

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

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

Service Providers

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

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

Homebound Determination

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

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

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

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

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

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

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

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

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

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

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

Exclusions and Limitations

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

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

Authorization Guidelines

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

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

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

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

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

Physician Certification

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

Physician Recertification

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

Ongoing Care

Participating providers initiate home health care services as follows:

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

For more information, select any subject below:
Skilled Nursing Services (Medicare, HMO and PPO only)

Skilled Nursing Services

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

The following are skilled services other than skilled nursing services:

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

Skilled Nursing Observation and Evaluation

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

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

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

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

Hospice Care

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

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

Select any subject below:

Hospice 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) | 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
- 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.

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 a Health Net contracted home infusion provider.

Shared risk PPGs should utilize a Health Net contracted home infusion provider or they will be liable for claims payments.

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

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

Human Growth Hormone and Antihemophilic Factor

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

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

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

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)

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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

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

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

Coverage

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

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

Resources

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

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

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

The following information does not apply to Medi-Cal

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

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

For more information on, select any subject below:

Bariatric Surgery Services (HMO and PPO only)

Bariatric Surgery Services

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

Health Net covers bariatric surgical procedures and services when medically appropriate in accordance with Health Net's Bariatric Surgery National Medical Policy. This includes the treatment of morbid obesity, including

abdominoplasty or lipectomy, and is authorized by Health Net and performed by Health Net Bariatric Performance Centers (PDF).

Outpatient Services

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

This section contains general member benefit information on outpatient services.

Select any subject below:

- Coverage Explanation
- 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.

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

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

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

Auxiliary Aids and Services

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

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

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

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

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 | Ancillary | Participating Physician Groups (PPG)

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

Covered Services

Coverage of TMJ is limited to the following:

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

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

Exclusions and Limitations

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

For more information, select any subject below:

- Payment MEDICARE HMO

Payment

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

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

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

Transgender Services

Provider Type: Physicians | 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

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 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 provider for laboratory services for the following lines of business:

- Point of Service (POS)
- PPO
- Fee-for-service (FFS):
    - HMO
    - Medicare Advantage (MA)
    - Medi-Cal

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

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

Radiation Therapy

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

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

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

Claims and Provider Reimbursement

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

This section describes claims and provider reimbursement

Select any subject below:

Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

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

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

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

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

- Subscriber identification number
- Patient name
- Patient account number - recorded on the CMS-1500 or UB-04

- Health Net claim identification (ID) number
- Service dates
- Total billed
- Contract adjustment
- Amount paid - same as contract adjustment
- Total claims payable
- Total check amount - total claims payable

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

Accessing Claims on the New Health Net Portal

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

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

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

Adjustments

Provider Type: Physicians | Ancillary

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

Balance Billing

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

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

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

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

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

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

Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered.

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

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

For more information, select any subject below:

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

- Missed Appointments MEDI-CAL

Billing 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

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.

Field Name	Required Information
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)
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

Field Name	Required Information
	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
Subscriber (name, address, DOB, sex, and member ID required)	2000B and 2010BA	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Provider taxonomy		Box 33B and Box 24	Box 57
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	2000C and 2010CA	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Principal diagnosis and additional diagnoses	Loop 2300 HI segment qualifier BK (ICD9) or ABK (ICD10)	Box 21	Box 66
Diagnosis pointers (up to 4)	Loop 2410 SV107	Box 24E (A-L)	N/A
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76

Form Fields	Electronic	CMS-1500	UB-04
Rendering provider	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)	NPI in Box 24J	N/A
Service facility information	Loop 2310C or 2310E NM1 with 77 qualifier (if differs from billing provider)	Box 32	N/A
Procedure code	Loop 2400 SV segment	Box 24D	Box 44 if applicable
NDC code	Loop 2410 LIN segment with N4 qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
UPN	Loop 2410 LIN segment with appropriate UP, UK, UN qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
Value codes (for accommodation codes, share of cost, etc.)	Loop 2300 HI segment with qualifier BE	N/A	Box 39, 40, 41
Condition codes	Loop 2300 HI segment with qualifier BG	N/A	Box 18-28
COB-other subscriber or third party liability	Loop 2320, 2330A and 2330 B	Box 9, if applicable (requires paper EOB from other payer), 10, 11	Box 50-62 (requires paper EOB from other payer)

Form Fields	Electronic	CMS-1500	UB-04
Claim DOS	Loop 2400 DTP segment with 472 qualifier	Box 24A	Box 45 for outpatient when required
Claim statement date	Loop 2300 with 434 qualifier	N/A	Box 6 from and through

Claims Rejection Reasons and Resolutions

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

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
01	Member's DOB is missing or invalid	Enter the member's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10	Section 2 [1]Non-standard submission or equivalent
02	Incomplete or invalid member information	Enter the member's Health Plan member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social Security number (SSN) should not be used. Check eligibility online, electronically, or refer to the member's current ID card to determine ID numbers	CMS-1500 box 1a UB-04 box 60	Section 2 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
06	Missing/invalid tax ID	Include complete 9-character tax identification number (TIN)	CMS-1500 box 25 UB-04 box 5	Section 1a [1]Non-standard submission or equivalent
17	Diagnosis indicator is missing POA indicator is not valid DRG code is not valid	Ensure 9/0 (“9” for ICD-9 or “0” for ICD-10) appears in field 66 for all claims. Ensure present on admission (POA) indicators are valid when billed. Ensure a valid DRG code is used in field 71. POA valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at time of inpatient admission. Leave blank if cannot be determined	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent
75	The claim(s) submitted has missing, illegible or invalid value	When box 24 is completed, then box 24G must be	CMS-1500 box 24D and 24G	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
	for anesthesia minutes	completed as well		
76	Original claim number and frequency code required	When submitting a corrected claim, for UB-04 box 64 and CMS-1500 box 22, you must reference the original claim. Claim numbers can be found on your Remittance Advice (RA)/ Explanation of Payment (EOP) or check claims status online. Do not include punctuation, words or special characters before or after the claim number. Submission ID from a reject letter is not a valid claim number. If not using frequency codes 7 or 8 leave boxes 64 and 22 blank. Submit contested claims to Medi-Cal Provider Contested Claims.	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by	UB-04 box 4	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit – Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)		
87	One or more of the REV codes submitted is invalid or missing	Include complete 4-digit revenue code	UB-04 box 42	N/A
92	Missing or invalid NPI	Enter provider's 10-character National Provider Identifier (NPI) ID	CMS-1500 box 24J and 33A UB-04 box 56	Section 1b [1]Non-standard submission or equivalent
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any	CMS-1500 box 24D UB-04 box 43	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		of these elements are missing, the claim will reject		
A7	Invalid/missing ambulance point of pick- up ZIP Code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pickup (POP) ZIP in box 23 in addition to the addresses in 24 shaded area or box 32	N/A
A9	Provider name and address required at all levels	Include complete provider billing address including city, state and ZIP Code	CMS-1500 box 33 UB-04 box 1	Section 1a [1]Non-standard submission or equivalent
AK	Original claim number sent when the claim is not an adjustment	When submitting an initial claim, leave CMS 1500 box 22 and UB-04 box 64 blank. Any values entered in these boxes will cause a claim to reject.	CMS-1500 box 22 UB-04 box 64	Section 4 [1]Non-standard submission or equivalent
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank. (for description	UB-04 box 67–67Q and 72A–72C	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		see Reject code 17)		
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A	N/A
C6	Other Insurance fields 9, 9a, 9d, and 11d are missing appropriate data	If the member has other health insurance, box 9, 9a and 9d must be populated, and box 11d must be marked as yes. If this is not provided, the claim will be rejected	CMS-1500 box 9, 9a, 9d and 11d	N/A
AV	Patient's reason for visit should not be used when claim does not involve outpatient visits	Include patient reason for visit for bill type 013x, 078x, and 085x (outpatient) when Type of Admission/Visit (Box 14) is 1 (emergency), 2 (urgent) or 5 (trauma) and revenue code 045x, 0516 or 0762 are reported.	UB-04 box 70a, b, c	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		Otherwise, do not populate		
HP	ICD-10 is mandated for this date of service	Submit with the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms according to the 5010 Guidelines requirement to bill this information. (for description see Reject code 17)	CMS-1500 box 21 UB-04 box 66	N/A
RE	Black/white, handwriting or nonstandard format	Use proper CMS-1500 or UB-04 form typed in black ink in 10 or 12 point Times New Roman font	N/A	N/A

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

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

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

- Evaluation and Management Services (E&M) - There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E&M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E&M services is

appropriate. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The documentation of each patient encounter should include the following:

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

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

Health Net reserves the right to request clinical records before or after claim payment to identify possible fraudulent or abusive billing practices, as well as any other inappropriate billing practice not consistent or compliant with the American Medical Association (AMA) CPT codes or guidelines, provided there is evidence such an investigation is warranted.

CMS-1500 Billing Instructions

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Insurance program identification	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other"	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
1a	Insured identification (ID) number	The nine-digit identification number on the member's ID card	Required
2	Patient's name (Last name, first name, middle initial)	Enter the patient's name as it appears on the member's ID. card. Do not use nicknames	Required
3	Patient's birth date and sex	Enter the patient's eight-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male or F= Female	Required
4	Insured's name	Enter the subscriber's name as it appears on the member's ID card	Conditional - Needed if different than patient
5	Patient's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line - In the designated block,	Conditional

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit zip code (ZIP + 4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1	
8	Reserved for NUCC	N/A	Not required
9	Other insured's name (last name, first name, middle initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
9a	Other insured's policy or group number	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan	Conditional REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan
9b	Reserved for NUCC	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
9c	Reserved for NUCC	N/A	Not required
9d	Insurance plan name or program name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name	Conditional REQUIRED if field 9 is completed
10 a, b, c	Is patient's condition related to:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in box 11	Required
10d	Claims codes (designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code	Conditional
11	Insured policy or FECA number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If box 10 a, b or c is marked Y, this field should be populated	Conditional REQUIRED when other insurance is available
11a	Insured date of birth and sex	Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		insured. Only one box can be marked. If gender is unknown, leave blank	
11b	Other claims ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number For worker's compensation of property and casualty: Required if known. Enter the claim number assigned by the payer	Conditional
11c	Insurance plan name or program number	Enter name of the insurance health plan or program	Conditional
11d	Is there another health benefit plan	Mark Yes or No. If Yes, complete field's 9a-d and 11c	Required
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary	Conditional - Enter "Signature on File," "SOF," or the actual legal signature

Field number	Field description	Instruction or comments	Required, conditional or not required
		to process and/or adjudicate the claim	
13	Insured's or authorized person's signature	Obtain signature if appropriate.	Not required
14	Date of current: Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	Conditional
15	If patient has same or similar illness. Give first date.	Enter another date related to the patient's condition or treatment. Enter the date in the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
16	Dates patient unable to work in current occupation	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY)	Conditional
17	Name of referring physician or other source	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)	Conditional - Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)
17a	ID number of referring physician	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	Conditional REQUIRED if field 17 is completed
17b	NPI number of referring physician	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used	Conditional REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used
18	Hospitalization on dates related to current services		Conditional
19	Reserved for local use - new form: Additional claim information		Conditional
20	Outside lab/ charges		Conditional
21	Diagnosis or nature of illness or injury (related items A-L to item 24E by line). New	Enter the codes to identify the patient's diagnosis and/or condition. List no more	Required - Include the ICD indicator

Field number	Field description	Instruction or comments	Required, conditional or not required
	form allows up to 12 diagnoses, and ICD indicator	than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment	
22	Resubmission code / original REF	For resubmissions or adjustments, enter the original claim number of the original claim. New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	Conditional - For resubmissions or adjustments, enter the original claim number of the original claim
23	Prior authorization number or CLIA number	Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If authorization, then conditional If CLIA, then required If both, submit the CLIA number Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization.

Field number	Field description	Instruction or comments	Required, conditional or not required
			CLIA number for CLIA waived or CLIA certified laboratory services
24 A-G Shaded	Supplemental information	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract rate • For detailed instructions and qualifiers refer to Appendix IV of this guide	Conditional - The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate
24A Unshaded	Dates of service	Enter the date the service listed in field 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
24B Unshaded	Place of service	Enter the appropriate two-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website	Required
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency	Not required
24D Unshaded	Procedures, services or supplies CPT/ HCPCS modifier	Enter the five-digit CPT or HCPCS code and two-character modifier, if applicable. Only one CPT or HCPCS and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim	Required - Ensure NDC or UPIN is included if applicable

Field number	Field description	Instruction or comments	Required, conditional or not required
24 E Unshaded	Diagnosis code	In 24E, enter the diagnosis code reference letter (pointer) as shown in box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in box 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-10 codes for the date of service, or the claim will be rejected/denied	Required
24 F Unshaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line	
24 G Unshaded	Days or units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one	Required
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral	Conditional - Leave blank or enter "Y" if the services were performed as a result of an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) referral
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	Conditional - Enter the appropriate qualifier for EPSDT visit
24 I Shaded	ID qualifier	Use ZZ qualifier for taxonomy. Use 1D qualifier for ID, if an atypical provider	Required
24 J Shaded	Non-NPI provider ID#	Typical providers: Enter the provider taxonomy code that corresponds to the qualifier entered in box 24I shaded. Use ZZ qualifier for taxonomy code	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Atypical providers: Enter the provider ID number.	
24 J Unshaded	NPI provider ID	Typical providers ONLY: Enter the 10-character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (such as DME, independent lab, home health, RHC/FQHC general medical exam)	Required
25	Federal Tax ID number SSN/EIN	Enter the provider or supplier nine-digit federal tax ID number, and mark the box labeled EIN	Required
26	Patient's account NO	Enter the provider's billing account number	Conditional - Enter the provider's billing account number
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment. Refer to	Conditional - Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the

Field number	Field description	Instruction or comments	Required, conditional or not required
		the back of the CMS-1500 (02-12) claim form for the section pertaining to payments	provider accepts assignment
28	Total charge	Enter the total charges for all claim line items billed - claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	Required
29	Amount paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to	Conditional REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing

Field number	Field description	Instruction or comments	Required, conditional or not required
		the right of the vertical line	
30	Balance due	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	Conditional REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)
31	Signature of physician or supplier including degrees or credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
32	Service facility location information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (PO box numbers are not acceptable here.) First line - Enter the business/facility/ practice name. Second line- Enter the street address. Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 codes), include the hyphen	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
32a	NPI - Services rendered	Typical providers ONLY: REQUIRED if the location where services were	Conditional Typical providers ONLY: REQUIRED if the location where

Field number	Field description	Instruction or comments	Required, conditional or not required
		rendered is different from the billing address listed in field 33. Enter the 10-character NPI of the facility where services were rendered.	services were rendered is different from the billing address listed in field 33.
32b	Other provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
33	Billing provider INFO & PH#	Enter the billing provider's complete name, address (include the ZIP + 4 code), and telephone number. First line -Enter the business/facility/ practice name. Second line - Enter the street address. Do not use commas, periods, or other punctuation in the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line- Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e., (555)555-5555). NOTE: The nine digit ZIP code (ZIP + 4 code) is a requirement for paper and EDI claim submission	
33a	Group billing NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI .	Required
33b	Group billing other ID	Enter as designated below the billing group taxonomy code.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. Atypical providers: Enter the provider ID number	

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 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. HMO, Medicare Advantage, and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and UB-04 form and computer generated claims using these formats.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Capitated Claims Billing Information

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

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

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

Capitated-Risk Claims

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

Electronically Submitted Claims

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

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

Denied Claims

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

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

Plan-Risk or Shared-Risk Claims

Plan-risk or shared-risk claims must be sent to Health Net for adjudication. Attach a copy of the Plan/Shared-Risk Cover Sheet to each group of claims the provider submits. Additionally, the claims should be separated and batched into plan or shared-risk services and claim types. All claims submitted to Health Net must be on CMS-1500, LTC form 25-1 or UB-04 claim forms, and must indicate the date of receipt by the participating physician group (PPG). Claims for plan-risk or shared-risk services must be submitted to Health Net.

The following information must be included on every claim:

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

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

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

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

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

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

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

Excessive Fees by Hospital-Based Providers

Provider Type: Participating Physician Groups (PPG)

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

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

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

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

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

1. Determine whether complications or other factors justify the charge. If there is justification, pay the amount billed and end the process. If there is no justification, proceed to the next step.
2. Contact the provider and attempt to resolve the difference. If there is no resolution, proceed to the next step.
3. Pay all outstanding charges, but notify the provider that this is being done under protest and that the PPG intends to seek a peer review of the matter by the local medical society.
4. Call the California Component Medical Societies for assistance in selecting the appropriate California county medical society to hear the protest. The correct county medical society is the one located in the same geographical area as the provider whose charge is in dispute.
5. Call the county medical society and ask for instructions for submitting cases for peer review.
6. If the PPG is informed that a member has been contacted by a collection agency, in addition to paying all outstanding charges, inform the collection agency in writing that the PPG is responsible for paying for the service and that the PPG has made payment, but that the validity of the charge is in dispute. State that the disputed excessive fee is to be subjected to a medical society peer review. Request that, in view of these facts, the collection agency take no action that might impair the credit rating of the member.

Shared-Risk Claims

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

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

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number, which is located on the member's ID card
- Provider name and address
- ICD-10 diagnosis code
- Service dates
- Billed charge per service
- Current year CPT procedure or U-92 (CMS-1450) revenue code
- Place of service or UB-92 or UB-04 bill type code
- Submitting provider tax identification number and national provider identifier (NPI) number
- Member name and date of birth as indicated on the member ID card
- State license number of the attending provider

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

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

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

Anesthesia Procedure Code Modifiers with the Minute Qualifier

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

Professional anesthesia capitated encounters billed with specific modifiers must use the minute qualifier, MJ. If you use the unit qualifier, UN, an edit will reject the encounter. The edit applies regardless of the date of service.

This change follows the Health Insurance Portability and Accountability Act (HIPAA) 5010 HIPAA 837 Companion Guide.

Use the MJ qualifier with these modifiers:

- AA
- AD
- QK
- QS
- QX
- QY
- QZ

Modifiers, other than the ones listed above, can process with the UN qualifier and not cause an edit.

If a professional encounter claim is sent with the above listed modifiers and the UN qualifier, the edit display will read: ANESTHESIA QUALIFIER IS INCORRECT. Resend a corrected capitated encounter with the MJ qualifier.

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 &

Report #	Name	Description
		Medicaid Services (CMS) to determine risk scores.
BRM 28	SB260 Reconciliation Report	Summarizes eligibility and remittance data.
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 ProcessingHMO and Medicare
- Eligibility Guarantee Under COBRAPPO
- Eligibility Guarantee Under COBRAHMO

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

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

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

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, 7 calendar days.

Providers must complete an HIV case report for each confirmed HIV test not previously reported and send it to the local health officer for the jurisdiction where the health care provider facility is located.

Providers must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express, or registered mail or other traceable mail
- Person-to-person transfer with the local health officer or their designee

Providers may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV
- A component of HIV
- Antibodies to, or antigens of, HIV, including:
    - HIV antibody (HIV-Ab) test
    - HIV p-24 antigen test
    - Western (Wb) blot test
    - Immunofluorescence antibody test

  A health care provider that orders a laboratory test used to identify HIV, a component of HIV, or antibodies to or antigens of HIV must submit to the laboratory a pre-printed laboratory requisition form that includes all documentation specified in 42 CFR 493.1105 (57 FR 7162, Feb. 28, 1992, as amended at 58 FR 5229, Jan. 19, 1993) and adopted in Business and Professions Code, Section 1220.

The person authorized to order the laboratory test must include the following when submitting information to the laboratory:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Date biological specimen was collected
- Name, address and phone number of the health care provider and the facility where services were rendered, if different

Most laboratories are also required to report confirmed tests to the local health office; however, this does not relieve the provider's reporting responsibility. Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing sites other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

Reporting Requirements for Hepatitis and Sexually Transmitted Infections

When a provider reports a case of hepatitis or a sexually transmitted infection (STI), the report must include the following information, if known:

- Hepatitis information including the type of hepatitis, type-specific laboratory findings, and sources of exposure
- STI information on the specific causative agent, syphilis-specific laboratory findings, and any complications of gonorrhea or Chlamydia infections

Tuberculosis Reporting and Care Management

Tuberculosis (TB) reporting is done immediately by phone or fax to expedite the process. The Confidential Morbidity Report form (PDF) should be used to notify the local health department's Communicable Disease Reporting Divisions. When reporting a case of TB, the health care provider must provide information on the

diagnostic status of the case or suspected case; bacteriological, radiological and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons; and a list of the anti-tuberculosis medications administered to the member. In addition, a report must be made any time a person ceases treatment for TB, including when the member fails to keep an appointment, relocates without transferring care, or discontinues care. Further, the local health officer may require additional reports from the health care provider.

The health care provider who treats a member with active TB must maintain written documentation of the member's adherence to their individual treatment plan. Reports to the local health officer must include the individual treatment plan, which indicates the name of the medical provider who specifically agreed to provide medical care, the address of the member, and any other pertinent clinical or laboratory information that the local health officer may require.

In addition, each health care provider who treats a member for active TB must examine or arrange for examination of all persons in the same household who have had contact with the member. The health care provider must refer those contacts to the local health officer for examination and must promptly notify the local health officer of the referral. The local health officer may impose further requirements for examinations or reporting.

Prior to discharge from an inpatient hospital, health care providers must report any cases of known or suspected TB to the local health officer and receive approval for discharge. The local health officer must review and approve the individual treatment plan prior to discharge.

Tuberculosis Care Management

When requested by the primary care physician (PCP) or local county health TB control officer, the Care Management Department provides assistance with coordination of the member's care. All cases referred to the Care Management Department are managed by gathering demographic and medical information. The care managers analyze the data, assess the member's needs, identify potential interventions, and follow the interventions with the member, family and health care team, within the limits of confidentiality. Following the evaluation, the care manager notifies the provider about the member's eligibility for the Care Management Program.

Primary Care Physician Responsibilities

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

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

Federal Lobbying Restrictions

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

United States Code Title 31, Section 1352, prohibits the use of federal funds for lobbying purposes in connection with any federal contract, grant, loan, cooperative agreement, or extension, or continuation of any of them. Participating providers are required to develop and comply with filing procedures as follows:

- File a declaration with the plan Net certifying that no inappropriate use of federal funds has occurred or will occur (use Certification for Contracts, Grants, Loans, and Cooperative Agreements Form (PDF)). This extends to any subcontract a participating provider may have that exceeds $100,000 in value. In these cases, the participating provider is required to collect and retain these declarations
- File a specific disclosure form if non-federal funds have been used for lobbying purposes in connection with any line of business (use Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF))
- File quarterly updates, such as a disclosure form at the end of any calendar quarter in which disclosure is required or in which an event occurs that materially affects the previously filed disclosure form

While the statute and related regulations do not specify that the $100,000 limit mentioned in the first bullet is to be calculated annually, the plan believes it reasonable to apply the $100,000 threshold to the term of the Provider Participation Agreement (PPA). If the PPA term is for one year, renewable automatically if not terminated, the threshold would renew at the beginning of each new one-year term. If it is a multiyear term, the calculation of the threshold would be based on the payments received throughout the multiyear term.

Participating providers who complete the Certification for Contracts, Grants, Loans, and Cooperative Agreements Form should send it directly to their assigned provider relations and contracting specialist.

Participating providers are required to comply with applicable state laws and regulations and plan policies and procedures. The contents of the operations manuals are supplemental to the PPA and its addendums. When the contents of the operations manuals conflict with the PPA, the PPA takes precedence.

Health Net Affiliates

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

Below is a listing of certain Health Net affiliates. Health Net affiliates and subsidiaries, including those listed below, as well as any other subsidiary or affiliate of Health Net not listed, may opt to periodically access the *Provider Participation Agreement* (*PPA*) for covered services delivered by providers under those benefit programs in which providers participate.

- Arizona Complete Plan
- California Health and Wellness Plan
- Health Net Community Solutions, Inc.
- Health Net Federal Services, LLC.
- Health Net Health Plan of Oregon, Inc.
- Health Net Insurance Services, Inc.
- Health Net Life Insurance Company
- Health Net of California, Inc.
- Managed Health Network, Inc.
- MHN Government Services, Inc.

- Network Providers LLC.
- Wellcare of California, Inc.

Material Change Notification

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

In accordance with AB 2907 (ch. 925, 2002) and AB 2252 (ch. 447, 2012), Section 1375.7 (c)(3) of the Health and Safety Code and Section 10133.65 (d)(3) of the Insurance Code, the health care provider's Bill of Rights, the plan is required to give notice at least 45 business days in advance to participating providers, including dental providers in reference to coverage of medical services only, when the plan intends to amend a material term of a manual, policy or procedure document referenced in the Provider Participation Agreement (PPA). The term material is defined as a provision in a contract to which a reasonable person would attach importance in determining the action to be taken with respect to the provision. If the change is required by federal or state law or an accreditation entity, a shorter notice period may apply.

The plan informs participating providers of material changes through provider updates and letters and announcements on the provider website. Once finalized, such changes are incorporated into the provider operations manuals. Information sent to providers through provider updates and letters is also added to the text of the appropriate operations manuals. The provider has the right to negotiate and agree to material changes. If an agreement cannot be reached, the provider has the right to terminate the PPA prior to implementation of the material change.

Nondiscrimination

Provider Type: Physicians | 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

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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

When the plan is the primary carrier, the participating provider is entitled to bill the other carrier as secondary after the provider has received the plan's adjudication decision.

A member is not entitled to an itemized statement reflecting the cash value of the services provided by the participating provider and covered by the plan (compliance with a request for itemization could enable a member to obtain unjust payment from an insurer or to document an itemized tax deduction far in excess of the actual cost).

A member is entitled to a statement documenting copayments made to the participating provider and charges for services not covered by the plan.

When Wellcare By Health Net is the primary payer and the member is enrolled in our exclusively aligned Dual Special Needs Plan (D-SNP), the secondary claim will be automatically forwarded to Health Net for payment on the Medi-Cal covered portion.

Refer to Claims Reimbursement and Balance Billing sections for more information.

When the Plan is the Secondary Carrier

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

When the plan is the secondary carrier, the participating provider is entitled to receive payment from the primary carrier for services provided directly to the member.

The participating provider should obtain the signature of the member who is the policyholder with the other carrier on a standard Assignment of Benefits form.

The participating provider should also obtain from the member any claim form the other carrier might require.

Upon receiving an adjudication decision from the primary carrier, the participating provider submits a secondary claim to the plan with an attachment of the primary carrier's Explanation of Benefits (EOB). When the participating provider expects to receive reimbursement from the plan amounting to more than any required copayment, do not collect a copayment.

If, after both carriers have reimbursed the participating provider, the provider has not received reimbursement equal to or greater than the amount that is due under the provider's Provider Participation Agreement (PPA), the member can be billed for the required copayment provided the total reimbursement from all sources is no greater than what is due under the provider's PPA.

When the primary carrier is another HMO and the member is enrolled with two different participating providers (one with the primary carrier and one with the plan), the member may receive services through either participating provider. The participating provider cannot deny services based on the plan's status as the secondary carrier.

Copayments

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

This section includes general information on the collection and verification of copayments.

Select any subject below:

- 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

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.

Eligibility

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

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

Select any subject below:

COBRA Continuation

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

Required Responses to Provider Inquiries Regarding Coverage

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

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

Election Period Requirements

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

- 60 days following the date the qualifying event would cause the qualified beneficiary to lose coverage
- 60 days following the date the notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage

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

Complete Responses During an Election Period

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

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

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

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

Grace Period Requirements

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

Complete Responses During a Grace Period

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

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

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

To comply with the requirements of the Department of Health and Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), the California Department of Health Care Services (DHCS), the California Disproportionate Share Hospital (DSH) Program, the Managed Risk Medical Insurance Board (MRMIB), and the National Committee for Quality Assurance (NCQA), Health Net requires information from its providers on members' use of health services.

Capitated participating physician groups (PPGs), hospitals and ancillary providers are required to provide complete encounter data about professional services rendered to Health Net members. These services include office visits; X-rays; laboratory tests; surgical procedures; anesthesia; physician visits to the hospital; inpatient, outpatient, emergency room, out-of-area, or skilled nursing facility (SNF) services; and all professional referral services. Capitated participating facilities (and physician groups with dual-risk contracts) are required to provide encounter data no less than monthly about institutionally-based services rendered to Health Net members.

Encounter data submissions must include all member-paid cost-share amounts, such as copayments, coinsurance and deductibles, applicable to the member's benefit. In addition, any rejected encounter data must be corrected and resubmitted in order for complete information and correct member-paid cost-share amounts to be captured and accumulated. Encounter data submission is also an integral part of the Health Net Quality of Care Improvement Program (QCIP) (applicable only for HMO and Point of Service (POS) products) and Healthcare Effectiveness Data and Information Set (HEDIS®). Refer to the Quality Improvement (QI) topic for more information about QCIP.

Dual-Risk Contracts Encounter Data Submission

Participating Physician Groups (PPG) | Hospitals

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

The following applies to Medicare dual-risk contracts:

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

Inpatient Admissions

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

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

Error Notification

Participating Physician Groups (PPG) | Ancillary | Hospitals

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

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

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

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

Lien Recoveries

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

Some hospitals assume the responsibility for collecting third-party recoveries through their contract with Health Net. The hospital may have its own lien right independent of the contractual lien described in Health Net's Evidence of Coverage (EOC) or Certificate of Insurance (COI), in which case the hospital asserts its own lien. It is the participating provider's staff responsibility to coordinate assertion of liens with the hospital and Health Net to avoid duplication or confusion. In the assertion of any lien, the hospital and the participating providers staffs must be clear about the nature and basis of the third-party recovery right they are asserting and any limitations on the lien under the law.

Member Cooperation

If the member refuses to honor the obligation to sign and return the lien form and declines to reimburse Health Net and the participating provider after settling with the third party, the participating provider should not delay or deny providing services or reimbursing the member's claims.

Noncompliance with Encounter Data Submission

Participating Physician Groups (PPG) | Ancillary | Hospitals

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

Professional and Institutional Capitated Encounter Submission Requirements

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

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

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

Capitated providers are contractually required to submit complete and correct data for all professional and institutional services performed. Before submitting encounter data, the submitter should contact the Health Net Encounter Department to discuss submission format and data requirements. Health Net currently accepts the ANSI 837 5010 X12 format.

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

Enrollment

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

This section contains general information and procedures regarding member enrollment.

Select any subject below:

- 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.

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 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 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.

Members must have the following 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.

Members have the following 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

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 and include:

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

Services not covered under Medicare but covered under Medi-Cal

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

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

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

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

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

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

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

Prior Authorization Process for Direct Network Providers

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

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

PCPs and specialists can fax requests for prior authorization to the Health Net – Prior Authorization using the appropriate form listed below:

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

The Health Net Medical Management Department accepts prior authorization requests for elective and urgent services by fax, phone or online.

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

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

Contact the Health Net – Prior Authorization or visit the Health Net provider website to obtain the status of an authorization.

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

Emergency services do not require prior authorization.

Peer-to-Peer Review Requests

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

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

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

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

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

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

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

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

How to request a peer-to-peer review

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

Product Descriptions

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

This section contains general information about Health Net health plans.

Select any subject below:

- 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

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.

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

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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:

Provider Oversight Overview

Participating Physician Groups (PPG)

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

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

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

Delegation Oversight Committee

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

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

Credentialing and Recredentialing

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

HEDIS® Reporting

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

Member Complaints, Appeals & Grievances

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

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

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

Preventive Care Guidelines

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

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

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

Notice to Change PPA

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

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

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

Calendar of Required PPG Submissions

Provider Type: Participating Physician Groups (PPG)

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

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

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
		Determinations (OD)		
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-Cal Community Health Plan of Imperial Valley and Medi-Cal Molina	UM Work Plan	Annually Semi-annual Quarterly	All LOB Initial - Annual: February 15 MCR & COMM - Semi-annual: August 15 Medi-Cal, Medi-Cal Molina and CalViva - Quarterly: Last day of the month following the end of the quarter
Claims	Medicare (HMO-H0562, SAP-H3561)	Provider Dispute Organization Determinations - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561)	Organization Determinations Claims - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561	Claims Reopens	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	AB72 IDRP Delegated Contact List	Annually	31-Oct-22

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
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
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	Claims Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
	and Medi-Cal_Molina			
Claims	Medi-Cal, 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
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

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

Organization Determinations

If a participating physician groups (PPGs) or hospitals is delegated for Utilization Management (UM) they must submit monthly to the Plan (delegation oversight team) the completed Organization Determination (OD)

template provided by the Plan , for each line of business, that includes all authorizations that a determination was completed in the previous month.

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

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

Reporting Elements & Submission

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

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

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

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

Corrective Action Plan

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a delegated entity is not in compliance with the Plan policies, contractual obligations or regulatory requirements, the Delegation Oversight Department may implement a corrective action process to correct the deficiencies.

- Delegate is notified of deficiency and requested to submit a corrective action plan (CAP) to address the deficiency and implement monitoring measures to avoid reoccurrence of deficiency.
    - The delegation oversight compliance auditor reviews the CAP for appropriateness and completeness and notifies the delegate of whether the CAP is approved.
    - If the Plan does not approve the CAP, the delegate is notified and asked to revise and resubmit the CAP to the Plan.
- If the delegate does not submit a CAP, or complete the actions in their CAP in a timely manner, the deficiency may be escalated to the Delegation Oversight Workgroup (DOW), Compliance and Network Management Leadership and or at a JOM to discuss deficiencies or to recommend further actions.
- If the delegate remains deficient it may be escalated to the Delegation Oversight Committee (DOC) to take formal actions up to and including de-delegation.

Fraud, Waste and Abuse

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

Fraud is intentional misrepresentation or deception for the purpose of obtaining payment or other benefits not otherwise due. Abuse includes those practices that are inconsistent with accepted sound fiscal, business or medical practices. The following are examples of fraud and abuse:

- Intentional misrepresentation of services rendered.
- Deliberate application for duplicate reimbursement.
- Intentional improper billing practices.
- Failure to maintain adequate records to substantiate services.
- Failure to provide services that meet professionally recognized standards of health care.
- Provision of unnecessary services .

Health Net is responsible for reporting to the state its findings of suspected fraud and abuse by participating providers or vendors under its Medi-Cal plans. Suspected fraud and abuse is identified through various sources that include aggregate data analysis, review of high-cost providers, review of CPT-4 codes with potential for over-use, members, the state, law enforcement agencies, other providers, and associates.

Providers and their office staff are legally required to report suspected cases of fraud and abuse to Health Net. Reports of suspected fraud may be made anonymously to the Health Net Fraud Hotline.

Member Appeals and Grievances

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

Health Net does not delegate member 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

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

Provider Type	Category	Standard
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	Q1 Q2 Q3 Q4	May 15 August 15 November 15 February 15

Filing Types	Requirements	Filing Period	Filing Deadline
	submit the most recent quarter.) Hospitals submit quarterly financial surveys to Health Net directly. (Note: Hospitals with financial statements prepared in the fiscal year must submit the most recent quarter.)		
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. 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. For Medi-Cal and Commercial lines of business, written policies and procedures must include disclosures pertaining to the use and oversight of the AI, algorithm or other software tool used in the UM determination process.

UM Committee

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

Delegated Prospective Review of Emergency Services

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

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

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

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

Encounter Data

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

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

Shared Risk UM Responsibilities

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

PPG Responsibilities

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

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

the applicable specialties of medicine and surgery. Physicians used to assist in medical necessity determinations are certified by one of the American boards of medical specialties.

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

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

PPG Responsibilities Regarding Nonparticipating Hospitals

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

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

Plan Responsibilities

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

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

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

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

DSNP prior authorization timelines

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

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

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

Fax prior authorizations to the Medi-Cal fax number listed under Health Net – Prior Authorization Department and include:

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

Services not covered under Medicare but covered under Medi-Cal

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

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

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

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

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

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

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

Delegation

Participating Physician Groups (PPG)

Health Net uses the Delegation Oversight Interactive Tool (DOIT) to evaluate structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information on these elements.

Health Net may delegate responsibility for activities associated with UM and Care Management services to its PPGs. Prior to participating with Health Net, and at least annually thereafter, Health Net conducts a review of each PPG. Health Net uses DOIT and other tools to evaluate the provider's facility and ability to deliver high-quality health care consistently and perform necessary administrative functions. Based on the audit scores and findings, if certain thresholds and criteria are met, the Delegation Oversight Committee (DOC) may deem it proper to delegate certain specific functions to the PPG to perform. If approved for delegation, a delegation agreement is forwarded to the PPG for signature. The delegation agreement includes a matrix that delineates the specific responsibilities delegated to, and accepted by, the PPG.

Upon delegation, Health Net may delineate specific and certain medical management functions for performance improvement. Performance improvement plans shall be shared with PPGs at regular intervals. Health Net and PPG medical directors are required to afford and actively participate in implementation of performance improvement plans.

Health Net systematically monitors and tracks provider compliance for all delegated providers because Health Net remains accountable to state and federal regulatory agencies for provider compliance even if certain functions are delegated.

Delegation Program Monitoring and Evaluation

Health Net may delegate responsibility for activities associated with utilization management (UM) and Care Management to participating providers. The DOC determines delegation status for each of the above functions, based initially on the results of pre-delegation comprehensive evaluation.

The DOC renders delegation decisions and provides guidance regarding delegation responsibilities through reports of annual audit results, oversight and monitoring, and periodic reviews of PPG specific data as reported from the Health Net Quality Improvement (QI) staff. This data includes, but is not limited to, complaints, access audit performance, member satisfaction results, and other quality of care data. Health Net may revoke, partial or complete delegation at any time if the committee determines that the PPG is no longer capable of performing delegated functions.

The DOC communicates delegation decisions for new PPGs or additional lines of business, as well as any recommendations and requests for root cause analysis and/or corrective action plans, to the PPG in writing by a series of standardized letters. The letters describe the functions or activities for which delegation is approved or denied, a delegation agreement, a delineation of the responsibilities of the PPG and the health plan, and the time frames for responses and submission of any required corrective plans. Health Net always remains accountable for all care and service delivered to members.

Delegation agreements for existing delegates are updated and signed as needed.

Health Net and PPGs may schedule operations meetings based on PPG requests or business needs identified by Health Net. Other criteria affecting PPG performance may necessitate additional meetings as determined by representatives. The meetings are multidisciplinary and provide a forum for both parties to discuss operational issues and PPG performance measures, which may include: access audit results, accreditation updates, UM audit results, care management audit results, appeals and grievance issues, denial issues, medical management issues, claims issues, eligibility, encounter data submission, pharmacy issues, required submissions report, provider profiles, and other information relevant to the member population served. Representatives from the PPG, Health Net and participating hospitals (if any) are included in the meetings.

Screening of prospective, concurrent and retrospective quality issues is conducted by the Quality Improvement staff upon notification of potential quality of care concerns. Indicators that may be reviewed include:

- Access - delay in authorization
- Access - delay in diagnosis
- Access - delay in service
- Communication
- Continuity of care
- Denial or delay of referral or authorization
- Denial of treatment
- Emergency services
- Encounter data submission
- Financial viability
- Inadequate care
- Inappropriate care or treatment
- Inappropriate denial of treatment
- Messy or unsanitary environment
- Misdiagnosis or inability to diagnose
- PPG claims and UM timeliness
- Physician incentive plan reporting
- Provider education
- Refusal to treat or care for members
- Rude, inappropriate or insensitive behavior
- Satellite addition and deletion
- Unprofessional and unethical behavior
- Urgent issues
- Utilization, credentialing and claims delegation oversight

Transitioning Delegated Functions

Delegated providers interested in transitioning any of their delegated functions, such as utilization management, claims, care management, or credentialing, to a new or different subcontracted entity or management services organization (MSO) must request approval from Health Net a minimum of 90 calendar days in advance of the anticipated transition date.

Submit written requests to your Provider Network Management (PNM) representative at least 90 calendar days in advance of the transition with the following information:

- Name of the new entity
- Delegated functions to transition to the new entity
- Contact name with contact information at the new entity

- Date of proposed transition

Approval or denial of the delegation transition to another entity is provided by Health Net once Health Net performs a comprehensive assessment and evaluation of the new entity.

Delegated providers are prohibited from initiating any transition plans to the new entity without Health Net's prior approval. Failure to comply with adequate notification and approval can jeopardize a provider's participation in Health Net's provider network.

Revoking Delegation

The DOC may, prior to any of the steps discussed in the Corrective Action Plan topic, decide to revoke delegation or send Health Net staff to the PPG for oversight and to assist in achieving compliance. When revoking delegation, Health Net follows written policies and procedures to ensure that there is no adverse effect on members.

Program Evaluation for Delegation

Oversight of PPG

Oversight of PPG operations includes annual ongoing review and monitoring of the written description of the utilization management (UM) program and operational assessment using the Delegation Oversight Interactive Tool (DOIT). PPG oversight includes, but is not limited to:

- Monitoring of denials.
- Compliance with health care criteria.
- Compliance with Health Net's approval and denial decision timelines standards.

During the assessment, the UM compliance auditor reviews policies and procedures, including the UM program to validate adherence to compliance standards. The UM compliance auditor will provide the PPG with details on all findings and request the PPG to outline a plan for improvement, where needed. The UM compliance auditor will review this plan and verify that it is appropriate based on the failures identified prior to approval.

Additional PPG documentation may be requested to complete the evaluation. The completed evaluation, with recommendations from the UM compliance auditor, is reviewed and presented to the Delegation Oversight Workgroup (DOW) and forwarded to the Delegation Oversight Committee (DOC) PPGs with extensive improvement plans are monitored closely until the changes are effective. A non-compliant PPG may be referred to the DOC for further action. Status reports are made to the DOC. PPGs not able to maintain the required standards are referred to the DOC for possible revocation of specified delegated activities.

In the event that a PPG disagrees with audit findings or the delegation decision of the DOC, the PPG may present the issue in dispute, in writing, to the chairperson of the DOC within 10 business days of receipt of the determination.

Delegation Assessments

Health Net evaluates the PPG's UM program pre-contractually and at least annually thereafter. To guide the assessment and provide consistency, Health Net uses a standard set of evaluation criteria driven by regulatory requirements and guidelines. Criteria is applied based on the lines of business delegated to the PPG.

The UM compliance auditors will perform these evaluations. The UM compliance auditor communicates with PPGs regarding the UM and care management (CM) program and standards. The UM compliance auditors are the principal liaison for regulatory requirements between Health Net and the PPGs and play an integral role in helping PPGs maintain compliance with Health Net's expectations.

Delineation of Delegation Responsibilities

Structural elements are basic requirements that must be developed in order to maintain an effective utilization management (UM) program. These elements are developed and approved to provide a process to support UM activities. The elements of a provider's UM program are reviewed, revised and approved annually. Health Net uses the Delegation Oversight Interactive Tool (DOIT) for evaluating structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information.

Revocation of Delegated Medical Management

Health Net reserves the right to revoke delegated status when the PPG has failed to meet and maintain established standards. Capitation payments may be adjusted when revocation of medical management functions occurs.

Delegated Review Processes - Concurrent, Prospective and Retrospective

Participating physician group (PPG) utilization review (UR) staff should perform concurrent reviews daily. PPGs may be required to communicate their concurrent review findings to Health Net medical management staff daily, or as requested by the Utilization Management (UM) and Care Management (CM) staff. The objective of PPG concurrent reviews is to assess clinical information during a member's hospital stay, coordinate the discharge plan, assist in determining medical necessity at the correct level of care, and perform the quality improvement screening.

The first review occurs within 24 hours of admission to confirm that the member is in the appropriate setting and is receiving medically necessary care, and to begin discharge planning. The PPG utilization management nurses review the member's continued stay using standardized nationally recognized criteria, such as InterQual® Guidelines. If a concurrent review does not confirm the need for continued stay, alternative care or a less acute level of care must be considered.

PPGs must develop processes to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Health Net is responsible for a concurrent review of out-of-area admissions for delegated PPGs, except for PPGs with financial responsibility for out-of-area services, according to the PPG's Provider Participation Agreement (PPA). Refer to the Out-of-Area Services discussion for more information. PPGs are responsible for working with Health Net to determine and facilitate the transfer of a member back into the network when appropriate, and the member is stable.

Prospective Review Process

A prospective review is performed to determine the medical necessity of elective referrals to specialty or ancillary care, inpatient admissions and outpatient procedures.

Requests for prior authorization of elective referrals, admissions or procedures are received by the participating physician group (PPG) from the primary care physician (PCP) or specialist. The PPG determines medical necessity through the use of standardized nationally recognized criteria and approves or denies the request. Refer to the Referrals and Prior Authorization topics for additional information.

Performance standards for turn-around times for review of, determination and decision notification for requests for prior authorization vary by line of business and the urgency of the request. Refer to the Utilization Management Timeliness Standards for Commercial, Medi-Cal and Medicare plans on the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp.

The PPG is obligated to provide oversight and documented monitoring of the utilization review process for medical appropriateness whenever this process is performed by a sub-delegated review organization. The PPG may not sub-delegate a function or activity to an entity whose delegation status with Health Net is currently denied or revoked for that function or activity. PPGs must notify Health Net prior to any sub-delegation agreement.

The UM Compliance Auditor periodically educates the PPG on plan tools, provides performance data, and evaluates performance using the provider assessment tools. Failure to meet the standards results in development of an issue in the DOIT and requires the PPG to create and action plan to remediate all findings. The PPG will submit an action plan for approval by the UM compliance auditor, who will review the action plan to ensure it is appropriate to address all findings. Once approved, the PPG must update the UM compliance auditors through DOIT of the status of each action plan. Once completed, the UM compliance auditor will decide if retesting is required for the issue.

Retrospective Review Process

A retrospective review is conducted on individual cases and with aggregate decision data. An individual case review helps to identify specific matters arising from an episode of care (for example, emergency room claims are reviewed for medical necessity and coverage). Problems identified through the retrospective review process are communicated to the PPG to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Utilization Management Responsibilities

Dual risk is restricted to participating physician groups (PPGs) with a dual-risk capitation agreement with the plan for professional and hospital services that have successfully met the plan performance standards. These groups have comprehensive administrative systems and have demonstrated an ability to perform utilization and care management activities effectively. At least annually, Health Net performs standardized program reviews of these PPGs to assess performance. Refer to the discussions in the Provider Evaluation for Delegation section for more information about the standardized program reviews, including the use of the Delegation Oversight Interactive Tool (DOIT).

PPG Responsibilities

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

- Having an effective, comprehensive utilization management (UM) and care management (CM) program in place that includes a UM committee comprised of actively practicing providers.
- Performing prospective, concurrent and retrospective reviews of medical care consistent with Health Net's goals and objectives.
- Cooperating with Health Net on medical management of all out-of-area admissions.

- Providing valid and reliable encounter data in a timely manner as requested and complies with the UM program.
- Reporting and analysis, including, but not limited to, the following:
    - Bed days/1,000, admits/1,000, length of stay (semi-annually for commercial and quarterly for Medicare)
        - For Health Net membership
        - For all managed care membership
    - Mental health (not applicable to Medi-Cal)
        - Days/1,000
        - Admits/1,000
        - Length of stay
    - Adoption of UM criteria
    - Monitor quality and timeliness of UM decisions and notifications
    - Approval and denials
    - Communication with members
- Preparing action plans for any out-of-the-ordinary UM indicators.
- Identifying children with potential California Children's Services (CCS)-eligible conditions and making referrals to the appropriate CCS county programs (applicable to Medi-Cal only).
- Having a written UM program description and plan approved by Health Net. The program and plan are evaluated annually for effect on members and providers and are reviewed and approved by the governing body of the PPG with signature and minutes documenting the approval.
- Having specific written procedures for precertification, concurrent and retrospective reviews, and care management that is supervised by qualified medical professionals and physician consultants from the applicable specialties of medicine and surgery. Physicians used to assist in medical necessity determinations are certified by one of the American boards of medical specialties.
- Having a UM committee composed of providers that makes determinations regarding approval or denial of health care services to members.
- The PPG's UM program and policies and procedures specifically outline member and provider notification of medically necessary determinations, including for approvals and denials. The denial process is clearly outlined and includes an appeal process.
- The PPG denial policy and procedure and member letters include required regulatory statements that clearly indicate the reason for the denial, alternative treatment suggestions and how the member can appeal directly to Health Net.
- The PPG denial process includes required regulatory statements that inform participating providers (for example, physicians, inpatient facilities, and ancillary providers) that they may appeal directly to Health Net.
- The PPG uses standardized nationally recognized UM medical review criteria to ensure consistent medical necessity determinations and interrater reliability (IRR) for all individuals involved in the UM process.
- The PPG and PPG-hospital affiliates report encounter data monthly. Care management cases (shared risk only) are reported to the Medical Management staff at the point of identification. Dual-risk PPGs delegated to perform complex case management according to NCQA standards are assessed annually for compliance with those standards. Refer to the Care Management section in the Utilization Management section for additional information on criteria for referral to the care management program.
- The PPG assists in identification of coordination of benefits and third-party payer information (not applicable to Medi-Cal).
- The PPG participates with Health Net in meetings as scheduled.
- The PPG administers member coverage based on the member's Evidence of Coverage (EOC).

- Failure of the PPG to meet the under- and over-utilization standards results in development of a corrective action plan that is submitted to Health Net for review and approval.
- PPG representatives participate with Health Net medical management committees as requested.

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

Health Net Responsibilities

In a dual-risk relationship, Health Net is responsible for the following:

- Contracting with the PPG for delegated UM functions.
- Assigning a UM Compliance Auditor to conduct pre-contractual evaluations, annual evaluations, and perform oversight and monitoring of the PPG to evaluate the PPG's UM program using the Delegation Oversight Interactive Tool (DOIT), including a review of denial and appeal process, and assisting the PPG in complying with these policies, state and federal regulations and accreditation standards.
- During the pre-contractual assessment with the PPG, the UM compliance auditor validates the PPG UM program adheres to the plan utilization and care management delegation criteria.
- Review and approval of the PPG UM program and conducting an annual audit of the PPG using the Delegation Oversight Interactive Tool (DOIT), including a review of denial files. If the PPG is not able to maintain the required standard of medical management, the Delegation Oversight Committee (DOC) may recommend revocation of specific delegated activities.
- A provider engagement and network specialist (formally provider network administrator) and a regional medical director (RMD) acts as a liaison with the PPG to resolve all contractual, operational and ongoing service problems.
- Oversight and monitoring when the PPG is delegated to perform complex care management for its dual-risk membership.
- PPG performance is monitored to determine if members are receiving timely medical services.

Requirements for PPGs Utilization Management Process

Health care service plans (HCSPs) and participating physician groups (PPGs) to which utilization management (UM) functions are delegated are required to employ and designate a senior medical director with an unrestricted California license to be responsible for ensuring that the UM processes are in compliance with the statute.

The name and direct telephone number (or extension) of the health care professional making the decision to delay, deny or modify a request for authorization of payment of service must be included in the notification letter to the requesting provider.

Health care service plans and PPGs to which UM functions are delegated are required to maintain telephone access for providers to request authorization for payment of health care services.

Timeliness Requirements for UM Decision Making

The health care service plan and its PPGs to which utilization review (UR) functions have been delegated are required to comply with standards established by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp to locate the Approved ICE Documents for the appropriate UM Timeliness Standards.

Disclosure of UM and UR Processes

Health care service plans (HCSPs) (or delegated participating physician groups (PPGs)) and disability insurers are required to disclose the UM and UR processes and criteria the plan and its delegated PPGs use to authorize, modify, defer, or deny health care services when requested by health care providers, members or the public.

Disclosures must be accompanied with the following text in its entirety:

"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Health care service plans and PPGs may charge reasonable fees for copying and postage costs and may make the information available electronically.

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.

Provider Status Change Notification Requirements

Providers are required to inform Health Net or the applicable PPG within five business days when either of the following occurs:

- The provider is not currently accepting new patients, when they had previously accepted new patients.
- The provider is currently accepting new patients, when they had previously not accepted new patients.

Additionally, if a provider who is not accepting new patients is contacted by a member or potential enrollee seeking to become a new patient, the provider is required to direct the member or potential enrollee to both Health Net for additional assistance in finding a provider and to the appropriate regulator listed below to report any inaccuracy with the provider directories.

Regulator	Contact Information	Line of Business
Department of Managed Health Care (DMHC)	1-888-466-2219 1-877-688-9891 (TDD) www.hmohelp.ca.gov	HMO, POS, HSP, Medi-Cal

Regulator	Contact Information	Line of Business
California Department of Insurance (CDI)	1-800-927-4357 www.insurance.ca.gov	EPO, PPO

PPGs must have policies in place that establish and implement processes to collect, maintain and submit provider demographic changes to Health Net within the required turnaround times.

Report of Inaccurate Information in Directories

When Health Net receives a report indicating that information listed in its provider directories is inaccurate by a potential enrollee, member, regulator or provider, Health Net promptly investigates the reported inaccuracy and, no later than 30 business days following receipt of the report, either verifies the accuracy of the information or updates the information in its provider directories, as applicable.

At a minimum, Health Net does the following:

1. Contacts the affected provider no later than five business days following receipt of the report.
2. Documents the receipt and outcome of each report, including the provider's name, location, and a description of Health Net's investigation, the outcome of the investigation, and any changes or updates made to the provider directories.
3. If changes to Health Net's directories are required as a result of the plan's investigation, the changes to the online provider directories must be made within the weekly turnaround time. For printed provider directories, changes must be made no later than the next required update or sooner if required by federal law or regulations.

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), Health Net will omit a provider, provider group or category of providers similarly situated from the directory if one of the below conditions is met.

- The provider is currently enrolled in the Safe at Home program.
- The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.
- A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.
- Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Providers must complete and sign the Directory Removal for At-Risk Providers form – Health Net (PDF), Directory Removal for At-Risk Providers form – Community Health Plan of Imperial Valley (PDF) or Directory Removal for At-Risk Providers form – CalViva Health (PDF) to be omitted from the directory.

Service and Quality Requirements

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

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

Access to Care and Availability Standards

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

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%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%
Urgent care services (SCP 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
Member to FTE physician ratio	1,200:1
Percent PCPs open practice	85% of PCPs accepting new members

Availability Standards	Performance Threshold
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 have access to urgent appointments within 48 hours

Access Measure	Standard	Performance Goal
Non-life threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Non-urgent appointment with non-physician behavioral health care provider for routine care[3]	Appointment within 10 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%

[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 and include:

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

Services not covered under Medicare but covered under Medi-Cal

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

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

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

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

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

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

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

Credentialing and Recredentialing

Provider Type: Hospitals

Hospitals are required to:

- Assure that the credentialing/recredentialing plan meets 100 percent of National Committee for Quality Assurance (NCQA) credentialing/recredentialing standards, and execute these activities according to that plan.
- Achieve and maintain no less than 70 percent compliance with the plan's medical records criteria for each primary care physician (PCP).
- Measure and report, as a network, data elements necessary to determine compliance with Healthcare Effectiveness Data and Information Set (HEDIS®) quality benchmarks.
- Achieve and maintain compliance with Department of Health and Human Services (HHS) standards.
- Achieve and maintain compliance with Centers for Medicare and Medicaid Services (CMS) standards.
- As applicable, maintain compliance/certification with Joint Commission on Accreditation of Healthcare Organization (JCAHO).

Health Net retains the right, based on quality issues, to terminate or suspend individual practitioners, providers, and sites, regardless of the credentialing delegation status of the PPG, IPA or entity.

Eligibility and Data Entry Requirements

Participating Physician Groups (PPG) | Hospitals

All participating physician groups (PPGs) and hospitals are required to enter the following into the PPG's or hospital's system:

- Eligibility and primary care physician (PCP) assignment information within two business days after receipt.
- New member information that is not yet on eligibility or capitation reports upon verification of eligibility.
- PCP changes requested by the member within two business days of receipt of requested change.

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 program provides an integrated, health management solution to improve the health and quality of life for Health Net members. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced clinical staff can assist members at-risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. The program includes a suite of services including wellness, disease management, care management and education and support tools for members.

Nurse Advice Line

Health Net's nurse advice line provides effective, appropriate and timely triage for health-related problems through experienced registered nurses and industry-approved guidelines and protocols. Nurse advice line registered nurses accurately identify member needs and ensure they are directed to the appropriate level of care for their situation -- whether it be providing self-care guidance or recommending a visit to urgent care or the emergency room. The service is offered 24 hours a day, seven days a week, 365 days a year, in English and Spanish, with translation services available for other languages. The nurse advice line phone number is listed on the back of Health Net members' identification cards.

Wellness Programs

Health Net offers members a number of wellness programs and resources through the Wellness Center on the Health Net member portal at www.healthnet.com. Members have access to the secure Health Profile, RealAge Test (health assessment) and Health Coaching through Sharecare. The Online RealAge program offers a variety of program health topics, including stress, nutrition, sleep and activity. Additional resources include online health challenges, trackers, videos and more.

Providers may refer members using the Care Management Referral form (PDF) to:

- The Craving to Quit tobacco cessation program, available to commercial members). members only).
- The Health Coaching Program (available to Commercial members only).

A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Disease Management Program

Health Net's high risk disease management program provides support to members with chronic conditions, including heart failure (HF), chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes, and asthma. Health Net disease management helps increase the efficiency and effectiveness of care, leads to more timely actions by the member, and helps develop more personalized and actionable solutions that ultimately lead to improved health outcomes. The goal of the disease management program is to support members' self-care skills, increase their self-confidence and help them work effectively with their providers to manage their health conditions. Health Net provides participants and their providers the programs, tools, connectivity, and information to make better health care decisions to:

- Slow the progression of the disease and the development of complications through proven program interventions.

- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines and care plans.
- Manage medications and enhance symptom control.
- Educate members regarding recommended preventive screenings and tests in accordance with national clinical guidelines.
- Reduce emergency room visits, hospitalization and medication errors, and prevent future occurrences.

Providers may refer members using Care Management Referral form (Commercial/Medicare Advantage (PDF)). A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Care Management

Health Net's complex care management program targets members with the most complex cases including behavioral health, often those with life-limiting diagnoses, and assists members who have critical barriers to their care. Trained nurse care managers or licensed clinical social workers provide telephonic contact with Health Net members, their families and caregivers. These members often have multiple comorbid conditions and need assistance in planning, managing and executing their care.

Health Net's telephonic case management program is available to high-risk members with less complex needs. The initial assessment and subsequent outreach is conducted over the telephone and may be face-to-face contact as needed. The Case Management department will continue coordination and re-assessments until the member's needs are met and the case can be closed. Use the Health Net Care Management Referral Form (PDF) to refer members for complex case management.

Health Net and its contracted providers are responsible for coordination and delivery of all dual special needs plan patients' Medicare and Medi-Cal benefits regardless of how the member receives their Medi-Cal benefits.

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: Participating Physician Groups (PPG)

Health Net encourages participating physician groups (PPGs) to provide health education and disease management programs to their members based on identified risks and Healthcare Effectiveness Data and Information Set (HEDIS®) standards.

PPGs should offer health education programs at each PPG delivery site (including satellites) with 5,000 or more Health Net members. Each PPG plans health education programs based on the recommended program criteria and protocols included in the Health Education Program subtopic.

Providing health education programs is part of the contractual agreement between Health Net and the PPG. The PPG is responsible for planning, implementing and evaluating its health education programs.

Health Education Program Offerings

All PPGs should recommend the following core topics: diabetes management, early prenatal education, baby care basics, and for Health Net Medicare Advantage (MA) members, a senior-specific health education or disease management program. Health Net encourages PPGs to provide additional program topics that reflect the breadth and depth of their members' needs. This includes efforts to identify members who smoke and to refer them to appropriate programs.

PPGs may select additional topics from the following list. PPGs are encouraged to select additional topics based on demographic and diagnostic data specific to their members.

Category	Examples
Maternal, infant and child health	VBAC, childbirth preparation, breastfeeding
Circulatory	hypertension, hypercholesterolemia
Respiratory	COPD, asthma
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:

- Baby Care Basics Protocol HMO
- Early Prenatal Education Program Protocol HMO
- Smoking Cessation Program MEDICARE HMO PPO EPO

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 Provider Network Management Department monitors. Refer to the Service and Quality Requirements discussion under the Provider Oversight topic for detailed information on access standards.

Health Net analyzes results in order to identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency room services, appropriate and timely access to care, and Americans with Disabilities Act (ADA) and language assistance program compliance. Health Net reports results as required to the Centers for Medicare and Medicaid Services (CMS) and DHCS.

Quality Improvement HAC Program

Provider Type: Hospitals

Health Net's Quality Improvement (QI) Hospital-Acquired Condition (HAC) program is designed to monitor patient care and to encourage quality improvement efforts in hospitals. The QI HAC program assesses member claims data to identify potential HACs; conducts outreach to hospitals to request details about each case; and follows up with further investigation through Potential Quality Issue referrals when appropriate. In the event that problems are identified, Health Net requests that hospitals assess their programs so that protocols can be revised to prevent such events in the future. The program is informed by guidance from CMS and The Leapfrog Group, which represents purchasers and employer groups, to help ensure that evidence-based protocols are followed for all members to ensure safe patient care. Refer to hospital-acquired conditions for more information on the HAC process and billing.

Quality Improvement and Health Equity Transformation Program

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

The Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to monitor, evaluate, and take effective action to address any needed improvements in the quality and health equity of care

of all Covered Services delivered to Health Net members, regardless of whether those services were delegated to a subcontractor, downstream subcontractor, or network provider. The QIHETP is continuous.

As a part of the QIHETP, Health Net is responsible for delivering quality care that enables all members to maintain health and improve or manage a chronic illness or disability. Health Net must ensure quality care in the following areas:

1) clinical quality of physical health care;

2) clinical quality of behavioral health care focusing on prevention, recovery, resiliency and rehabilitation;

3) access to primary and specialty health care providers and services;

4) availability and regular engagement with PCP;

5) continuity of care and care coordination across settings and at all levels of care, and

6) member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care and care coordination.

Health Net must apply the principles of continuous quality improvement (CQI) to all aspects of its service delivery system through analysis, evaluation, and systematic enhancements of the quantitative and qualitative data collection and data-driven decision-making, up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources, feedback from members, community partners, network providers, and any other identified issues.

The purposes and goals of the QIHETP are to:

- Support Health Net's strategic business plan to promote safe, equitable and high quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement a Quality Improvement and Health Equity Annual Plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data

collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

Health Net utilizes several methods to measure access to care, including telephone-based surveys and member experience surveys. Provider satisfaction with the timeliness and usefulness of information received from other physicians and various care settings is also assessed on a regular basis to measure the coordination of care in the network. Opportunities for improvement are identified by examining provider ratings of key elements in the following functional areas: access and availability, case management, prior authorization, cultural and linguistic services, concurrent review, and discharge planning.

The QIHETP includes a written program description and a Quality Improvement and Health Equity Annual Plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement and Health Equity Committees (QIHECs) and the Health Net board of directors (BOD) approve and monitor the annual Health Net QI and HE programs and the QI and HE work plans. A written summary of QIHEC activities, findings, recommendations, and actions are prepared after every meeting and are submitted to the board of directors.

Quality Improvement Program and Compliance and HEDIS

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

Health Net tracks and monitors quality of care and service in a number of ways, including through the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of service and quality of care provided by organized delivery systems. It is the most widely used set of performance measures in the managed care industry. Participation in this effort allows health care purchasers and providers to compare Health Net's performance relative to other health plans and to identify opportunities for improvement.

In addition, Health Net participates in various quality improvement collaboratives, including:

- California Quality Collaborative (CQC), a program that seeks to improve clinical care and service for all Californians by providing strategies at the point of care. Various programs are available to providers to improve chronic disease care, patient satisfaction and efficiency. For a listing of educational programs and patient satisfaction and condition management resources, providers can visit www.calquality.org.
- The Leapfrog Group: Health Net works closely with The Leapfrog Group, purchases their data, and promotes their ratings and standards to network hospitals, members and the community.

- Cal Hospital Compare: Health Net collaborates with Cal Hospital Compare on a range of issues and contracts with them to obtain Poor Performer and Honor Roll reports and associated data files to inform hospital quality initiatives. .

Quality of Care Issues

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

Potential quality of care issues are reviewed by a Health Net medical director and, based on findings, are given a severity level and, as indicated, submitted to the peer review committee (PRC) for appropriate resolution. At a minimum annually, the number, severity, actions taken, and trends noted are aggregated and reported to the Health Net Quality Improvement Committee.

Providers use the Potential Quality Issue (PQI) Referral form Health Net Referral Form (PDF), Potential Quality Issue (PQI) Referral form – Community Health Plan of Imperial Valley (PDF) or CalViva Health Referral Form (PDF) to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation.

Referrals

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

This section contains general information on referrals.

Select any subject below:

- 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

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

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 • 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	• 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 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

Hospitals are required to report any Health Net member's inpatient admissions (including Individual & Family Plan (IFP) within 24 hours (or one business day when an admission occurs on a weekend or holiday), seven days a week. To report an admission, contact the Health Net Hospital Notification Unit. Failure to notify according to requirements in the Provider Participation Agreement (PPA) may result in a denial of payment.

On receipt of admission notification, Health Net creates a tracking number and provides to the reporting party. The tracking number is not an authorization that services are covered under a member's benefit plan. Any services authorized by Health Net at the time of notification or thereafter are noted in the Health Net notification system. The tracking number is also transferred electronically to the Health Net claims processing system. To report a Health Net member inpatient admission, contact the Health Net Hospital Notification Unit.

Notification of after-hours admissions may be made by phone (the information is recorded by voicemail), fax, or web. On the next business day, a Health Net representative verifies eligibility, obtains information regarding the admission and, if applicable, provides a tracking number for the case.

When reporting inpatient admissions, providers must have the following information:

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).

- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number.
- For obstetrical (OB) delivery admissions, include newborn sex, weight, apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

Timely notification of Health Net member inpatient admissions assists with timely payment of claims, reduces retroactive admission reviews and enables Health Net to concurrently monitor member progress. Health Net requires the following facilities to notify BOTH the Health Net Hospital Notification Unit AND the PPG (if applicable) or provider of a member's inpatient admission within 24 hours (or one business day when an admission occurs on a weekend or holiday) for the following services:

- All inpatient hospitalizations.
- Skilled nursing facility (SNF) admissions.
- Inpatient rehabilitation admissions.
- Inpatient hospice services.
- Emergency room admissions.

Requests for Authorization for Post-Stabilization Care at Non-Participating and Participating Hospitals

Health Net is responsible for the coverage and payment of emergency services and post-stabilization care services to the provider that furnishes the services. This can be a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Requests for post-stabilization authorization

The requirement to request authorization applies to both in-network and out-of-network hospitals when treating members.

The hospital’s request for authorization is required once the Health Net member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for inpatient post-stabilization care. A patient is “stabilized,” or “stabilization” has occurred, when, in the opinion of the treating provider, the patient’s medical condition is such that, within reasonable medical probability, no material deterioration of the patient’s condition is likely to result from, or occur during, the release or transfer of the patient.

Hospitals are required to provide the treating physician and/or surgeon’s diagnosis and any other relevant information reasonably necessary for Health Net to decide whether to authorize post-stabilization care or to assume management of the patient’s care by prompt transfer.

How to request post-stabilization authorization

To request authorization for post-stabilization care, the hospital must **call** the Hospital Notification Unit.

A hospital’s notification to Health Net of emergency room treatment or admission **does not** satisfy the requirement to request post-stabilization care. Post-stabilization requirements do not apply if the member has **not** been stabilized after emergency services and requires medically necessary continued stabilizing care.

A hospital's contact with any other phone or fax number or website, or the patient's participating physician group (PPG), to request authorization to provide post-stabilization care does not satisfy the requirements of the above required procedures. Do not contact the member's PPG or any other Health Net phone, fax number or website to request Health Net's authorization for post-stabilization care.

Behavioral health emergencies

Marketplace/IFP (Ambetter HMO and PPO) and Employer Group HMO/POS and PPO members: Health Net covers mental health and substance use disorder treatment that includes behavioral health crisis services provided to a member by a 988 crisis call center, mobile crisis team or other behavioral health crisis services providers, regardless of whether that provider or facility is in network or out of network. Hospitals must use the above number to request authorization for members' post-stabilization care once they are deemed stable but require facility-based care.

Providers can access the Transitions of Care Management (TRC) Worksheet to:

- Help support transitions of care to ensure appropriate documentation and timely report of the notification of a Medicare patient's inpatient admission, receipt of discharge information, and patient engagement after inpatient discharge.
- Reconcile discharge medications with the most recent medication lists to optimize HEDIS® and Star Rating scores and improve care coordination.

Response time to requests

Health Net must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is considered authorized.

Failure to request post-stabilization authorization

Health Net may contest or deny claims for post-stabilization care following treatment in the emergency department or following an admission through a hospital's emergency department when Health Net does not have a record of the hospital's request for post-stabilization care via phone or a record that Health Net provided the hospital an authorization for such services.

Required documentation

All requests for authorization, and responses to requests, must be documented. The documentation must include, but is not limited to:

- Date and time of the request.
- Name of the provider making the request.
- Name of the Health Net representative responding to the request.

Conditions of financial responsibility

Health Net is financially responsible for post-stabilization care services that are not pre-authorized, but are administered to maintain, improve, or resolve the member's stabilized condition if the Plan:

- Does not approve or disapprove a request for post-stabilization care within 30 minutes.
- Cannot be contacted.
- Is unable to reach an agreement with the treating provider concerning the member's care and a Plan physician is not available for consultation.

If this situation applies, the Plan must give the treating provider the opportunity to consult with a Plan physician. The treating provider may continue with care of the member until a Plan physician is reached or one of the following criteria is met:

- A Plan physician with privileges at the treating provider's hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility for the member's care through transfer;
- The Plan and the treating provider reach an agreement concerning the member's care; or
- The member is discharged.

Wellcare By Health Net Medicare Dual Special Needs (D-SNP)

Per the State Medicaid Agency Contract (SMAC) with Department of Health Care Services (DHCS) contracted hospitals and SNFs must use one of the following methods, in a timely manner, to inform the member's D-SNP and the Medi-Cal plan of any hospital or SNF admission, transfer or discharge. Hospitals and SNFs must use either:

- A secure email or data exchange through a Health Information Organization or,
- An electronic process approved by DHCS.

This information must be shared to the extent allowed, under applicable federal and state law and regulations, and not be inconsistent with the member's expressed privacy preferences.

Contracted hospital	Must notify the D-SNP member's MCP either immediately prior to, or at the time of, the member's discharge or transfer from the hospital's inpatient services, if applicable.
Contracted SNFs	Must notify the D-SNP member's MCP within 48 hours after any SNF admission. For discharges or transfers, SNFs must notify the D-SNP member's MCP in advance if possible, or at the time of the member's discharge or transfer from the SNF

Facilities can identify the member's Medi-Cal plan by using the State online eligibility system (AEVS).

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) UM vendors and Molina Health Care in Los Angeles County for Medi-Cal. Following an evaluation of the operational capabilities of their UM program, Health Net's decision to delegate UM is based on results of pre-delegation reviews and committee approval. Health Net does not delegate UM functions to individual participating providers. Health Net staff perform UM functions when operational functions are not delegated.

When Health Net delegates UM operational functions, delegates are required to establish a formal UM program that describes how the delegated UM processes are performed and monitored. Health Net evaluates the effectiveness of the delegate program via ongoing monthly performance reporting, quarterly system validation reviews and annual reviews. Corrective actions are issued for below standard performance and when necessary, decisions regarding continued delegation will be reviewed by the Health Net Delegation Oversight Committee.

Health Net medical directors and provider engagement account executives are the principal liaisons between Health Net medical management and PPGs. Health Net UM and quality improvement (QI) staff support these directors and account executives. They play an integral part in helping PPGs and delegates meet the expectations of Health Net and its members. They play an important role in improving provider performance, provider satisfaction and clinical outcomes for our members through monthly engagement with providers and timely issue resolution.

Contacts

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
- 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

Contacts

This section contains general contact information for providers.

AcariaHealth

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

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AcariaHealth (preferred hemophilia provider):
844-538-4661
Fax: 844-750-0827

Access2Care

Non-emergency standard transportation services are arranged through Access2Care™.

844-515-6876

Available 24 hours a day, 7 days a week. For more information, visit the Access2Care website.

Scheduling Non-Emergency Standard Transportation Services Through Access2Care

Providers should refer to the table below and contact Access2Care to arrange for medically necessary or covered transportation services.

Access2Care Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Standard days and hours of customer service center operation for routine reservations	Monday through Friday, 8 a.m. to 8 p.m. Pacific time (PT)
Weekend and holiday schedule	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
	(July 4), Labor Day, Thanksgiving, and Christmas
Routine transportation requests	Requires a 72-hour notification
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service.
Hours of operation for urgent and same-day reservations	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance and hospital discharges	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Toll-free phone numbers	Reservations: 844-515-6876

Access to Interpreter Services

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

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Health Net offers language assistance services to its participating providers. Participating providers may request no-cost translation and interpreter support for a Health Net member at to the provider or member.

Medi-Cal

Interpreter support is available 24 hours a day, seven days a week. The California Department of Management Health Care (DMHC) requires that interpreter services, according to Section 1367.04 of the Health and Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations, are coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. To allow sufficient time for scheduling, providers must request interpreter services a least five business days prior to the member's appointment. For sign language requests, please request this at least 10 business days prior to the member's appointment.

If an appointment is rescheduled, it is very important to reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may also assist in identifying the member's language need. This service is provided at no cost to Health Net participating providers.

Participating providers may request interpreter services by using the following numbers:

Medi-Cal Interpreter Services

Member Plan	Hours of Availability	Contact Number	Required Information
Medi-Cal (Amador, Calaveras, Kern, Inyo, Los Angeles, Mono, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne)	24 hours a day, 7 days a week	800-675-6110	Member name and Health Net ID number, appointment date and time
Medi-Cal/CalViva (Fresno, Kings and Madera)	24 hours a day, 7 days a week	888-893-1569	Member name and the Plan ID number, appointment date and time
Medi-Cal/Community Health Plan of Imperial Valley	24 hours a day, 7 days a week	833-236-4141	Member name and the Plan ID number, appointment date and time
Behavioral Health	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)	800-647-7526	Member name and the Plan ID number, appointment date and time

HMO, Medicare Advantage HMO, PPO

Health Net requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to also reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may assist in identifying the member's language need. This service is provided at no cost to Health Net participating providers.

Participating providers may request interpreter services by using the following numbers:

Commercial Interpreter Services

Line of Business	Phone Number	Hours of Availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Employer Group HMO, POS and PPO	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays
Behavioral Health	800-647-7526	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)

Medicare Interpreter Services

Line of Business	Telephone Number	Hours of Availability
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time

AIDS Waiver Program

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

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The AIDS Waiver Program provides home and community-based services as an alternative to institutionalized care for those with AIDS or symptomatic HIV.

Kern

Department of Health Services Chronic Disease Prevention Program 1800 Flower Avenue Bakersfield, CA 93306 661-321-3000 (referrals and education)

Kings

Kings County Department of Public Health, Division of Nursing and Community Services 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-589-0652

Los Angeles

AIDS Project Los Angeles 3550 Wilshire Blvd., Suite 300 Los Angeles, CA 90010-2404 213-201-1600

ALTAMED Health Services Corp HIV Services Division 5427 East Whitter Boulevard Los Angeles, CA 90022-4101 323-869-5449

Minority AIDS Project 5149 West Jefferson Boulevard Los Angeles, CA 90016 323-936-4949

St. Mary Medical Center Care Program 1045 Atlantic Avenue, Suite #1016 Long Beach, CA 90813 562-624-4900

Tarzana Treatment Center 18646 Oxnard Street Tarzana, CA 91356-1486 818-342-5897
Fax: 818-345-6256

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 559-675-7893

Riverside

1695 North Sunrise Way Palm Springs, CA 92262 760-323-4197

Sacramento

RX Staffing and Home Care, Inc. 4640 Marconi Avenue, Suite 1 Sacramento, CA 95821 916-979-7300

Sacramento County CCS Program 9616 Micron Avenue, Suite 640 Sacramento, CA 95827 916-875-9900 Fax: 916-854-9500

San Bernardino

1695 North Sunrise Way Palm Springs, CA 92262 760-323-4197

San Diego

North County Health Services AIDS Case Management 150 Valpreda Road, Suite 101B San Marcos, CA 92069 760-736-6725
Fax: 760-736-3210

San Joaquin

San Joaquin County Public Health Services - AIDS/Communicable Diseases Program 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3822
Fax (209) 468-8222

Stanislaus

Stanislaus County Community Health Services 830 Scenic Drive, Bldg. 3 Modesto, CA 95350 209-558-4800
Fax 209-558-4905

Alcohol and Drug Treatment Services

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

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Drug/Medi-Cal (D/MC) Alcohol and Drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. The state of California Alcohol and Drug Programs oversee the alcohol and drug programs. Health Net, its affiliated health plans, and subcontracting providers are available to coordinate referrals for members requiring substance abuse treatment and services. Members receiving services under the D/MC program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member.

Amador

Amador County Alcohol & Drug 10877 Conductor Blvd, Sutter Creek, CA 95685 209-223-6412

Calaveras

Calaveras County Substance Abuse 891 Mountain Ranch Rd Bldg L, San Andreas, CA 95249 209-754-6555

Fresno

Fresno County Alcohol and Drug Program 559-493-2185

Inyo

Inyo County Alcohol & Drug 162 Grove St J, Bishop, CA 93514 760-873-5888

Kern

Kern County Mental Health 2151 College Avenue Bakersfield, CA 93305 661-868-8111

Kings

Kings County Department of Public Health 330 Campus Drive Hanford, CA 93230 559-584-1401

Los Angeles

Los Angeles County Office of Alcohol and Drug Programs 714 West Olympic Boulevard Los Angeles, CA 90015 323-948-0444

Madera

Madera County Behavioral Health Services 14227 Road 28 Madera, CA 93639 559-673-3508

Mono

Mono County Alcohol & Drug Services 452 Old Mammoth Rd, Mammoth Lakes, CA 93546 760-924-1740

Sacramento

Alcohol and Drug System of Care Sacramento County Department of Health and Human Services 3321 Power Inn Road, Suite #120 Sacramento, CA 95826 916-874-9754

San Diego

Office of Alcohol and Drug Programs 888-724-7240

San Joaquin

San Joaquin County Behavioral Health Services - Substance Abuse Services 620 N Aurora ST., Suite #1
Stockton, CA 95205 209-468-3800
Fax (209) 468-3723

Stanislaus

Stanislaus County Behavioral Health and Recovery Services Stanislaus Recovery Center 1904 Richland Avenue Ceres, CA 95307 888-376-6246
209-541-2121

Tulare

Alcohol and Drug Treatment 559-636-4000

American Specialty Health Plans

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

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HMO, Medicare Advantage HMO, and PPO

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

Health Net contracts with American Specialty Health Plans, Inc. (ASH Plans) to administer and arrange chiropractic, acupuncture and massage therapy services for Health Net members in accordance with the member's applicable benefit plan.

HMO members 800-972-4226
Medicare Advantage members: 800-678-9133

April–September

Monday through Friday, 5 a.m. – 8 p.m. Pacific time (PT)

October–March

7 days a week, 8 a.m. – 8 p.m. PT

For more information, visit the American Specialty Health website.

Medi-Cal

Health Net contracts with American Specialty Health Plans, Inc. (ASH Plans) to administer and arrange acupuncture services for Health Net members.

800-972-4226, option 2.

Animas Diabetes Care LLC

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

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Provider of insulin pumps and supplies.
877-937-7867

Apria Healthcare Inc

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

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Provider of durable medical equipment (DME) services, excluding orthotics.

800-277-4288

ATG Rehab Specialists Inc

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

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Provider of rehabilitation equipment services.

877-489-3651

Byram Healthcare Centers, Inc.

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

Byram Healthcare Centers, Inc.

877-902-9726
Fax: 866-992-6331

Byram Healthcare website

Behavioral Health Provider Services

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

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If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or his or her staff may contact Health Net for a referral to a behavioral health provider. Health Net also assist with member eligibility, benefits and general questions behavioral health services.

844-966-0298

California Department of Health Care Services Subacute Contracting Unit

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

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Facilities can contact the California Department of Health Care Services (DHCS) Subacute Contracting Unit (SCU) to request an application to be contracted for subacute care and receive Medi-Cal subacute care reimbursement.

California Children's Services Paneling Inquiries

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

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Paneling Inquiries:

Visit the Department of Health Care Services website or contact the Integrated Systems of Care Division, Provider Enrollment Unit at 916-552-9105. Select option 5, then option 2.

California Department of Social Services State Fair Hearing

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

California Department of Social Services State Hearings Division
P.O. Box 944243, MS 19-17-37 Sacramento, California 94244-2430

Fax: 916-651-2789 Phone: 800-743-8525 (voice) and 800-952-8349 (TTY)

California Children's Services Program

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

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The California Children's Services (CCS) program provides specialized medical care, rehabilitation services, and case management to children with medical or surgical conditions who meet program eligibility requirements. It is essential that physicians identify children with CCS-eligible conditions and arrange for their timely referral to the county CCS program.

Amador

County Department of Health 10877 Conductor Blvd., Ste. 400 Sutter Creek, CA 95685

209-223-6630
Fax: 209-223-3524

Calaveras

County Department of Health Mail: 891 Mountain Ranch Road San Andreas, CA 95249-9713 700 Mountain Ranch Road, Suite C2 San Andreas, CA 95249

209-754-6460
Fax: 209-754-1710

Fresno

1221 Fulton Mall, Room #101 P.O. Box 11867 Fresno, CA 93721

209-754-6460
Fax: 559-455-4789

Imperial

935 Broadway Street El Centro, CA 92243-2396

442-265-1455
Fax: 442-265-1481

Inyo

County Department of Health 1360 N. Main Street, Suite 203-C Bishop, CA 93514 760-873-7868
Fax: 760-873-7800

Kern

1800 Mt. Vernon Avenue Bakersfield, CA 93306

661-321-3000
Fax: 661-868-0268

Kings

Kings County Department of Public Health, Division of Nursing and Community Services 330 Campus Drive Hanford, CA 93230-4375 559-852-4693
Fax: 559-582-6803

health net

Los Angeles

9320 Telstar Avenue, Suite #226 El Monte, CA 91731-2849 800-288-4584
Fax: (855) 481-6821

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638-5715 559-675-4945
Fax: 559-675-7803

Mono

County Department of Health Mail: P.O. Box 3329, Mammoth Lakes, CA 93546 1290 Tavern Road, Suite 246 Mammoth Lakes, CA 93546 760-924-1848
Fax: 760-924-1831

Riverside

Riverside County Department of Health 10769 Hole Ave, #220 Riverside, CA 92505-2869 951-358-5401
Fax: 951-358-5198

Sacramento

9616 Micron Avenue, Suite #640 Sacramento, CA 95827 916-875-9900
TTY 800-735-2929
Fax: 916-854-9500

San Bernardino

San Bernardino County Department of Health 150 E Holt Blvd, 3rd Floor Ontario, CA 91762 909-458-1637
Fax: 909-986-2970

San Diego

Department of Health 6160 Mission Gorge Road, Suite 400 San Diego, CA 92120 619-528-4000
Fax: 619-528-4087

San Joaquin

San Joaquin County Public Health Services 420 South Wilson Way Stockton, CA 95205

209-468-3900
Fax 209-953-3632

Stanislaus

830 Scenic Drive, Bldg. 3 PO Box 3088 Modesto, CA 95353-3088 209-558-7515
Fax: 209-558-7862

Tulare

1062 South K Street Tulare, CA 93274 559-687-6915
Fax: 559-713-3740

Tuolumne

County Department of Health 20111 Cedar Road North Sonora, CA 95370-5939 209-533-7404
Fax: 209-533-7406

CalViva Health Medi-Cal Member Services Department

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

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To ensure appropriate coverage of medical services for Medi-Cal members, CalViva Health requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, CalViva Health directs inquiries from members to CalViva Health's Medi-Cal Member Services Department. Provider inquiries are directed to the CalViva Health liaison Provider Engagement Network Specialists when applicable.

The CalViva Health Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the CalViva Health Member Handbook and other member-informing materials are translated into the required threshold languages.

CalViva Health's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.

- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests

The CalViva Health toll-free number is printed on the back of the member's identification card 888-893-1569 (TTY 711). CalViva Health is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the CalViva Health Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. CalViva Health's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the CalViva Health Nurse Advice Line (N24) when applicable.

CalViva Health Member Services Department; Open 24/7 phone number:888-893-1569
Fax: 844-837-5947 or 800-281-2999

CalViva Health Medi-Cal Provider Services Department

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

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As a prepaid health care delivery system, CalViva Health has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, CalViva Health directs inquiries from providers to CalViva Health's Medi-Cal Provider Services Department or to CalViva Health's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

CalViva Health's Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates, and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the CalViva Health Medi-Cal Recommended Drug List (RDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/ PCP/PPG reassignment for non-compliant members

The CalViva Health Medi-Cal Provider Services Department phone number 888-893-1569, option 2.

Fax: 844-837-5947 or 800-281-2999

Eligibility and claims status available online.

Provider's may use the Medi-Cal Claims Inquiry email box for claim status only if the provider portal is down or not working. This box is only for claim status and denial inquiries.

CalViva Health Nurse Advice Line

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

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The CalViva Health Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour telephone service for instructions, medical condition assessment and advice. The CalViva Health Medi-Cal Member Services Department coordinates member access to the CalViva Health Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

888-893-1569

Cancer Information Services

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

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If a participating physician group (PPG), hospital, ancillary provider, or physician is not affiliated with a mammography center, a list of certified centers is available from Cancer Information Services or the Food and Drug Administration's (FDA's) website at www.fda.gov

800-422-6237

Care Ride Unit

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

Phone: 833-236-9695

Fax: 833-701-0051

Case Management Department

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

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Contact the Case Management Department at:

Commercial

Email: Case.Management.Referrals@healthnet.com
Fax: 800-745-6955

Medi-Cal

Email: CASHP.ACM.CMA@healthnet.com
Fax: 866-581-0540

Case Management for Health Net, CalViva Health or Community Health Plan of Imperial Valley (CHPIV) Medi-Cal members with Adverse Childhood Experiences (ACEs):

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

- 866-801-6294 if the member has a Health Net or CHPIV plan.
- 888-893-1569 if the member has a CalViva Health Medi-Cal plan.

Centers for Medicare & Medicaid Services

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

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The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the Department of Health and Human Services that governs the Medicare, Medicaid, Clinical Laboratories (under CLIA program), and Children's Health Insurance programs to help ensure that eligible beneficiaries in these programs are able to get high-quality health care.

Health Net has entered into an agreement with CMS to administer health care services to eligible Medicare beneficiaries. Participating providers are required to adhere to all legislative and regulatory requirement issued by CMS.

To obtain additional information regarding CMS, refer to the CMS website.

Centene Vision Services

Contact Centene Vision Services to locate a participating optometrist or optician from whom Medi-Cal member may receive covered services (routine vision examination/refraction, lenses and frames) when medically necessary.

- Fresno, Kings and Madera Counties: 844-876-7123
- Amador, Calaveras, Imperial, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne counties: 844-820-8600

WELLCARE BY HEALTH NET (MEDICARE ADVANTAGE) Contact Centene Vision Services to locate a participating optometrist or optician from whom Wellcare By Health Net member may receive covered services (routine vision examination/refraction, lenses and frames) when medically necessary. Provider Services for Wellcare By Health Net: 866-392-6058

Centralized Transplant Unit

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

Fax numbers for organ transplant reviews and authorizations:

- For individual Medicare plan members: 833-769-1143
- For employer group Medicare members: 833-769-1142

Children's Medical Services

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

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The Children's Medical Services (CMS) Branch of the California Department of Health Services (DHS) oversees state-funded public health programs for children, including California Children's Services (CCS).

Children's Medical Services Branch Office MS 8100 P.O. Box 997413 Sacramento, CA 95899-7413

Communicable Disease Reporting

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

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To protect the public from the spread of infectious, contagious, and communicable disease, health care providers are required by law to report communicable diseases to the local health officer. Every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, must notify the local health department (LHD).

Reports must be made using the Confidential Morbidity Report. A completed copy of the report must be sent to the Communicable Disease Control division of the county health department.

Amador

10877 Conductor Blvd Sutter Creek, CA 95685 209-223-6407
Fax: 209-223-1562

Calaveras

700 Mountain Ranch Road, Suite C-2 San Andreas, CA 95249 209-754-6460
Fax: 209-754-1709

Fresno

Communicable Disease Control County of Fresno 1221 Fulton Mall P.O. Box 11867 Fresno, CA 93775 559-445-3324

Fax: 559-445-3535

Imperial

935 Broadway Street El Centro, CA 92243 442-265-1444
Fax: 442-265-1440

Inyo

1360 N. Main Street Bishop, California 93514 760-873-7868
Fax: 760-873-7800

Kern

Department of Public Health Services Chronic Disease Prevention Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 Fax: 661-321-3000

Kings

Kings County Department of Public Health, Communicable Disease Services 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-584-5672

Los Angeles

Acute Communicable Disease 313 North Figueroa Street, Room #117 Los Angeles, CA 90012 888-397-3993 888-397-3778 or 213-482-5508

HIV Epidemiology Program 600 South Commonwealth, Room #805 Los Angeles, CA 90005 213-351-8196

Long Beach Health Department 562-570-4000

Pasadena Health Department 626-744-6005

Pediatric HIV and AIDS Reporting Program 313 North Figueroa Street, Room #203 Los Angeles, CA 90012 213-250-8666

Sexually Transmitted Disease Program 2615 South Grand, Room #500 Los Angeles, CA 90007 213-744-3251 > Fax: 213-749-9602

Tuberculosis Control Program 2615 South Grand, Room #507 Los Angeles, CA 90007 213-744-6160
Fax: 213-749-0926

Madera

Madera County Department of Public Health, Communicable Disease Control Program 14215 Road 28
Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Mono

1290 Tavern Road, Suite 246 PO Box 3329 Mammoth Lakes, CA 93546 760-965-9897
Fax: 760-924-1831

Sacramento

Sacramento County Public Health 7001-A East Parkway, Suite 600A Sacramento, CA 95823 916-875-5881 (online reporting and set-up assistance)
Fax: 916-854-9708

San Diego

San Diego Department of Community Epidemiology Health & Human Services Agency 3851 Rosecrans Street
San Diego, CA 92110 619-692-8499
Fax: 858-715-6458

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3822
Fax: 209-468-8222

Stanislaus

Stanislaus County Health Services Agency Communicable Disease Program 820 Scenic Drive Modesto, CA 95350 209-558-5678 (Reporting Line)
209-664-6032 (After hours emergency/weekend - confidential phone number for reporting purposes only)
Fax: 209-558-7531

Tulare

Tulare County Department of Health Services 115 East Tulare Avenue Tulare, CA 93274 559-685-5720
Fax: 559-685-4835

health net

Tuolumne

20111 Cedar Road N. Sonora, CA 95370 209-533-7401
Fax: 209-533-7406

Community-Based Adult Services Centers

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

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Community-based adult services (CBAS), formerly Adult Day Health Care (ADHC), provides an alternative to institutionalization for eligible Medi-Cal members ages 18 and older.

Fresno

Adult Day Health Care of Fresno and Clovis 5757 North First Street Fresno, CA 93710 559-227-8600
Fax: 559-227-8200

Clovis Adult Day Health Care Inc. 50 West Bullard, Suite 113 Clovis, CA 93612 559-298-3996
Fax: 559-298-2074

Heritage Adult Day Health Care Center 5377 N. Fresno Street Fresno, CA 93710 559-222-0304
Fax: 559-222-2132

Heritage West 3677 W. Beechwood Avenue Fresno, CA 93711 559-261-0707
Fax: 559-261-9995

Valley Adult Day Health Care Center 4835 E. McKinley Avenue Fresno, CA 93703 559-454-0386
Fax: 559-454-0387

Imperial

Imperial County Area Agency on Aging 778 West State Street, El Centro CA 92243 442-265-7030 Fax: 442-265-7030

Alegria Adult Day Health Care Center 1101 C.N. Perry Avenue, Calexico, Imperial County CA 92231 760-768-8419

DayOut ADHC – Brawley 616 Main Street, Brawley, Imperial County CA 92227 760-344-5665

DayOut ADHC – El Centro 757 Main Street, El Centro, Imperial County CA 92243 760-337-8393

Kern

Aging and Adult Services 5357 Truxtun Avenue, Bakersfield, CA 93309 661-868-1000
Fax: 661-868-1001

Alzheimer's Disease Association of Kern County 5500 Olive Drive, Bakersfield, CA 93308 661-393-8871
Fax: 661-393-9973

Chateau Bakersfield Adult Day Health Care Center 824 18th Street, Bakersfield, CA 93301 661-322-4085
Fax: 661-323-1059

Delano Adult Day Health Care Center 1457 Glenwood Street, Delano, CA 93215 661-725-7070
> 661-725-9300

Los Angeles

A Plus Adult Day Health Care 3321 Tyler Avenue El Monte, CA 91731 626-579-6588
Fax: 626-579-6586

Antelope Valley Adult Day Health Care Center 42212 10th Street, Suite 8 Lancaster, CA 93534 661-949-6278
Fax: 661-949-6768

Ararat Adult Day Health Care Center 721 South Glendale Avenue Glendale, CA 91205 818-240-1721
Fax: 818-240-2160

Arcadia Adult Day Health Care Center 15 Las Tunas Drive Arcadia, CA 91007 626-447-9700
Fax: 626-446-5405

Arcadia of Hollywood Adult Day Health Care Center 860 North Highland Avenue Los Angeles, CA 90038
323-466-4122
Fax: 323-466-2340

Babylon Adult Day Health Care Center 5955 Lindley Avenue Tarzana, CA 91356 818-996-9300
Fax: 818-996-9173

Sacramento

AltaMedix 4234 North Freeway Blvd, Suite 500 Sacramento, CA 95834 916-648-3999
Fax: 916-648-1919

California Association for Adult Day Services 1107 9th Street, Suite 701
Sacramento, CA 95814 916-552-7400
Fax: 916-552-7404

Eskaton Adult Day Health Care Center - Carmichael 5105 Manzanita Avenue, Suite D Carmichael, CA 95608
916-334-0296
Fax: 916-348-6715

Health for All Adult Day Health Center - Meadowview 2730 Florin Road Sacramento, CA 95822 916-391-5591

Fax: 916-391-0264

Help to Recovery - Easter Seals Superior California 3205 Hurley Way Sacramento, CA 95864 916-485-6711
TTY: 916-485-9632
Fax: 916-485-2653

Rancho Cordova Adult Day Health Care Center 10086 Mills Station Road, Sacramento, CA 95827
916-369-1113
Fax: 916-369-1138

San Diego

AmeriCare Adult Day Health Care Center 340 Rancheros Drive, Suite 196 San Marcos, CA 92069
760-682-2424
Fax: 760-471-5104

Casa Pacifica ADHC Center 1424 30th Street, Suite C
San Diego, CA 92154 619-424-8181
Fax: 619-424-8151

Clairemont Villa Adult Day Health Center 10174 Old Grove Road San Diego, CA 92131 858-576-8575
Fax: 858-576-8424

Elm Adult Health Center 1220 Elm Avenue Imperial Beach, CA 91932 619-827-0573
Fax: 619-271-1284

George G. Glenner Alzheimer's Family Centers, Inc. 335 Saxony Road Encinitas, CA 92024 760-635-1895
Fax: 760-436-0949

280 Saylor Drive Chula Vista, CA 91910 760-420-1703
Fax: 760-420-0196

Hope Adult Day Health Care Center 11239-A Camino Ruiz San Diego, CA 92126 858-653-5916
Fax: 858-653-5295

Horizons Adult Day Health Care Center 14154 E. 8th Street, Suite 5
National City, CA 91950 619-474-1822
Fax: 619-474-1826

Loving Care Adult Day Health Care Center 2565 Camino Del Rio South, Suite 201 San Diego, CA 92108
619-718-9777
Fax: 619-718-9772

Neighborhood House Adult Day Health Care Center 851 South 35th Street
San Diego, CA 92113 619-233-6691
Fax: 619-233-6693

Poway Adult Day Health Care Center 12250 Crosthwaite Circle Poway, CA 92113 858-748-5044
Fax: 858-748-5405

San Ysidro Adult Day Health Care Center 3364 Beyer Boulevard San Ysidro, CA 92173 619-205-1373
Fax: 619-600-4867

Western Adult Day Health Care Center 240 Magnolia Avenue El Cajon, CA 92020 619-631-7222
Fax: 619-631-9228

Stanislaus

Stanislaus County Health Services Agency 830 Scenic Drive Modesto, CA 95350 209-558-7000

Tulare

To obtain information on the nearest CBAS center, call 855-689-7396.

Community-Based Adult Services Face-To-Face Request Line

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

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Providers must submit all Community-Based Adult Services (CBAS) requests, including requests for a face-to-face assessment, on the Health Net provider portal. Once logged in, go to the member's profile and select *Assessments* . Select *Fill Out Now!* next to CBAS Treatment Request.

Comprehensive Perinatal Services Program

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

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All pregnant members must have access to Comprehensive Perinatal Services Program (CPSP) services, which integrate health education, nutrition and psychosocial services with obstetrical care.

Amador

Amador County Public Health 10877 Conductor Blvd. 400 Sutter Creek, CA 95642 209-223-6407
Fax: 209-223-3524

Calaveras

Calaveras Public Health Department
891 Mountain Ranch Road San Andreas, CA 95249 209-754-6464
Fax: 209-754-6459

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3234

Imperial

935 Broadway Street El Centro, CA 92243 800-675-2229

Inyo

Inyo County Health Department
207 A West South Street Bishop, CA 93514 760-873-7868
Fax: 760-873-7800

Kern

Department of Public Health Services Comprehensive Perinatal Services Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 661-868-0523

Kings

Kings County Department of Public Health 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-584-5672

Los Angeles

Los Angeles 213-639-6419

Long Beach 562-570-4060

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Mono

Mono County Health Department P.O. Box 3329 Mammoth Lakes, CA 93546 760-924-1842
Fax: 760-924-1831

Riverside

951-358-5438

Sacramento

Sacramento County Department of Health and Human Services 7001-A East Parkway, Suite 600 Sacramento, CA 95823 916-875-5437
Fax: 916-875-5888

San Bernardino

800-227-3034

San Diego

3851 Rosecrans Street San Diego, CA 92110 619-542-4053

San Joaquin

San Joaquin County Public Health Services - CPSP 1601 E. Hazelton Ave Stockton, CA 95205 209-468-3004
Fax 209-468-2072

Stanislaus

Stanislaus County Health Services Agency

Maternal and Child Health Branch 830 Scenic Drive Modesto, CA 95350 209-558-6819

Tulare

559-685-2275

health net

Tuolumne

Tuolumne County Health Department
20111 Cedar Rd. N. Sonora, CA 95370 209-533-7401
Fax: 209-533-7406

Connect Hearing Inc

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

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888-608-7462

Connect Hearing website

County Mental Health Plan

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

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Services available under the Medi-Cal specialty mental health program are excluded from Health Net's coverage responsibilities. Primary care physicians (PCPs) provide outpatient mental health services, within the scope of their practice and coordinate referrals for members requiring specialty or inpatient mental health services.

County Mental Health Plan Contact Information

COUNTY	PHONE NUMBER
Amador	888-310-6555 or 209-223-6412
Calaveras	800-499-3030 or 209-754-6525
Fresno	559-253-9180
Imperial	760-482-2939

COUNTY	PHONE NUMBER
Inyo	800-841-5011
Kern	800-991-5272 or 661-868-8000
Kings	800-655-2553
Los Angeles	800-854-7771
Madera	888-275-9779
Mono	800-687-1101 or 760-924-1740
Riverside	800-706-7500
Sacramento	Sacramento County Mental Health Treatment Center 2150 Stockton Blvd. Sacramento, CA 95817 Adult Access team 916-875-1055 Fax: 916-875-1190 TTY: 916-874-8070 Child and Family Access team 916-875-9980 Fax: 916-875-9970 TTY: 916-876-8892 Psychiatric emergencies 916-732-3637 Toll-free 24-hour information line 888-881-4881
San Bernardino	888-743-1478
San Diego	888-724-7240
San Joaquin	209-468-8700 Crisis intervention line 209-468-8686
Stanislaus	888-376-6246
Tulare	559-624-7445 Emergency or crisis line: 800-320-1616
Tuolumne	800-630-1130 or 209-533-6245

County Relations/Service Coordination

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

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Public programs specialists interact with public health departments and programs and work with participating providers and Department of Health Care Services (DHCS) in administering public programs and services.

800-526-1898
Fax: 866-208-2240

Coram

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

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Health Net's preferred infusion provider

- Phone: 866-899-1661
- Fax: 866-843-3221

Custom Rehab Network

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

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Provider of custom rehabilitation equipment services.

800-276-6557

Community Health Plan of Imperial Valley Member Services Department

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

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To ensure appropriate coverage of medical services for Medi-Cal members, Community Health Plan of Imperial Valley requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, Community Health Plan of Imperial Valley directs inquiries from members to Community Health Plan of Imperial Valley's Medi-Cal Member Services Department. Provider inquiries are directed to the Community Health Plan of Imperial Valley liaison Provider Engagement Network Specialists when applicable

The Community Health Plan of Imperial Valley Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the Community Health Plan of Imperial Valley Member Handbook and other member-informing materials are translated into the required threshold languages.

Community Health Plan of Imperial Valley's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests.
- Handling complaints about Community Health Plan of Imperial Valley programs or staff

The Community Health Plan of Imperial Valley’s toll-free number is printed on the back of the member’s identification card: 833-236-4141 (TTY 711). Community Health Plan of Imperial Valley is available 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Community Health Plan of Imperial Valley Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Community Health Plan of Imperial Valley's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Community Health Plan of Imperial Valley Nurse Advice Line (N24) when applicable.

Community Health Plan of Imperial Valley Provider Services Center Opened 24/7 Phone Number 833-236-4141

Fax: 844-837-5947 or 800-281-2999

Community Health Plan of Imperial Valley Provider Services Department

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

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As a prepaid health care delivery system, Community Health Plan of Imperial Valley has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, Community Health Plan of Imperial Valley directs inquiries from providers to Community Health Plan of Imperial Valley 's Medi-Cal Provider Services Department or to CHPIV's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

Community Health Plan of Imperial Valley s Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates, and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the CHPIV Medi-Cal Recommended Drug List (RDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/ PCP/PPG reassignment for non-compliant members

The Community Health Plan of Imperial Valley Medi-Cal Provider Services Department toll-free telephone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Community Health Plan of Imperial Valley Provider Services Department Phone Number: 833-236-4141

Fax: 844-837-5947 or 800-281-2999

Eligibility and claims status available online.

Provider’s may use the Medi-Cal Claims Inquiry email box for claim status only if the provider portal is down or not working. This box is only for claim status and denial inquiries.

Community Health Plan of Imperial Valley Nurse Advice Line

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

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The Community Health Plan of Imperial Valley Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour phone service for instructions, medical condition assessment and advice. The Community Health Plan of Imperial Valley Medi-Cal Member Services Center coordinates member access to the Community Health Plan of Imperial Valley Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

833-236-4141

Delta Dental

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

855-643-8515

April–September
Monday through Friday
8 a.m. – 8 p.m. Pacific time (PT)

October–March
7 days a week
8 a.m. – 8 p.m. PT

Dental Benefit Providers

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

866-249-2382

April–September
Monday through Friday
5 a.m.– 8 p.m. Pacific time (PT)

October–March
7 days a week
5 a.m. – 8 p.m. PT

Denti-Cal

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

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Medi-Cal members are entitled to annual dental screenings, as described in the periodic health exam schedules. Primary care physicians (PCPs) refer members for dental services to Medi-Cal dental providers.

800-322-6384

Department Of Health Care Services

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

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The sterilization informational brochures are available online for downloading and printing. California Department of Health Care Services (DHCS)

Department of Insurance

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

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The Department of Insurance (DOI) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use Health Net's grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DOI. Providers, including participating physicians, may assist the member in submitting a complaint to the DOI for resolution and may advocate the member's position before the DOI. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

800-927-4357
213-897-8921

Department Of Managed Health Care

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

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The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use the grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DMHC. Providers, including participating physicians, may assist the member in submitting a complaint to the DMHC for resolution and may advocate the member's position before the DMHC. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

888-466-2219
800-400-0815
TTY: 877-688-9891

Contact DMHC

Department Of Social Services (DSS)

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

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The Department of Social Services (DSS) Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding fair hearings and grievances.

PO Box 944243 Mail Stop 19-37 Sacramento, CA 94244-2430

800-952-5253
TTY: 800-952-8349

Fax: 916-229-4110

Electronic Claims Clearinghouse Information

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

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Submit electronic claims for Health Net members to the appropriate clearinghouse:

Clearinghouse Information

CLEARINGHOUSE	PHONE NUMBER	WEBSITE	HEALTH NET PAYER ID NUMBER
Change Healthcare (fee-for-service only)	877-469-3263 or 800-792-5256	client-support.changehealthcare.com	68069 (Medicare and Individual Family Plans including Covered California) 95567 (Medi-Cal and Commercial)
Transunion (capitated encounters only)	Your account manager or 310-337-8530	www.transunion.com	95568 and 95570

The payer ID must be included with every claim.

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse.

EviCore Healthcare

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

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eviCore healthcare is responsible for prior authorization for select sleep and radiation therapy services.

Sleep

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: 866-999-3510

Radiation therapy

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: Radiation Therapy: 800-540-2406

Evolent Specialty Services, Inc.

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Evolent Specialty Services, Inc. (Evolent), formerly known as National Imaging Associates, Inc. (NIA), is responsible for prior authorization for advanced imaging services and cardiac imaging.

Prior authorization requests must be submitted to Evolent online or by phone as follows. Evolent does not accept fax submissions.

www.RadMD.com (24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours)

Evolent Specialty Services Contact Information

PRODUCT	HOURS OF OPERATION	PHONE NUMBER
Commercial	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4802
Medi-Cal	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4809

EyeMed Vision Care

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Health Net is contracted with Centene Vision Services to provide vision benefits to Health Net members for some plans. Centene Vision Services sub-delegates benefit administration to EyeMed. EyeMed provides

benefits for routine vision exams and eyewear through their network of optometrists, dispensing opticians and optometric laboratories.

Benefit administration for the routine vision examination varies by plan/product. Please verify coverage to determine if an appointment for a vision examination is covered through the participating physician group (PPG) or through EyeMed.

EyeMed Vision Care
Health Net Vision
4000 Luxottica Place
Mason, OH 45040

866-392-6058

Financial Oversight Department

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

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The Financial Oversight Department is responsible for tracking and monitoring the financial solvency of delegated providers. Contact them for assistance to submit quarterly financial updates or statements and for questions.

email: financeoversight-pa@healthnet.com

FitOn Health

FitOn Health gives Medicare members access to the best digital fitness and wellness content, fitness studios, and gyms. This benefit is covered under member's Medicare health plan at no additional cost. Members will be able to continue their current fitness routine while having access to a variety of new activities.

At the beginning of each month, credits are added to member's FitOn Health account. Members can use the credits at any fitness facility in the FitOn Health network.

For more information about this benefit, contact FitOn Health.

855-378-6683, select option 1

Have questions?

Email: move@fitonhealth.com

For more information, visit fitonhealth.com/help or fitonhealth.com/members.

Health Care Options (HCO)

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

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The Health Care Options (HCO) contractor processes Medi-Cal managed care enrollments and disenrollments. Refer members to the appropriate toll-free number for assistance.

Arabic 800-576-6881

Armenian 800-840-5032
Cambodian 800-430-5005

Cantonese 800-430-6006

English and other languages 800-430-4263

Farsi 800-840-5034

Hmong 800-430-2022

Korean 800-576-6883

Laotian 800-430-4091

Mandarin 800-576-6885

Russian 800-430-7007

Spanish 800-430-3003

Tagalog 800-576-6890

Telephonic device for the deaf and hearing impaired 800-430-7077

Vietnamese 800-430-8008

Health Net Care Management Department

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

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Health Net offers transition of care assistance that allows members who are receiving care to continue with their established non-participating provider. Approval decisions are based on individual review of member's care needs in relation to benefits and regulatory requirements.

- Medicare Case Management: 800-977-7915
- Commercial Case Management: 888-732-2730

Health Net Claims Submission

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

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Claims address for EPO, HSP and HMO products.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net Continuity and Coordination of Care Department

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

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Participating physician groups (PPGs) must immediately forward all pertinent documentation for investigational or experimental treatment for a terminal illness via fax or by overnight mail.

Fax: 866-295-4780

Health Net of California, Inc.
Continuity and Coordination of Care
Medical Management Department
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Credentialing Department

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

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The Health Net Credentialing Department is responsible for credentialing and recredentialing directly contracting providers and all providers affiliated with participating physician groups (PPGs) to which credentialing responsibilities have not been delegated. The Health Net Credentialing Department also oversees delegated and subcontracting credentialing activity.

20151 Nordhoff
Chatsworth, CA 91311
Fax: 800-655-4128

Health Net's Health and Wellness Referral Fax

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

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To refer a Health Net member to one of the programs for disease management, case management or complex case management, fax a referral to 800-745-6955 or 678-355-4018 for pregnancy notification only.

You can also email a referral fax.

Delegation Oversight Department

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

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The Health Net Delegation Oversight Department (previously Provider Oversight Department) oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies. The department conducts on-site due diligence evaluations prior to Health Net agreeing to contract with a provider and through on-site evaluations at least annually thereafter. Based on these evaluations, the Health Net Delegation Oversight Committee (DOC) determines which functions are to be delegated to the participating physician group (PPG). The Health Net DOC measures, monitors and oversees compliance of providers and requires corrective actions when deficiencies are discovered. The DOC is a multi-disciplinary committee comprised of, but not limited to, members from Health Net's Delegation Oversight, Health Care Services, Network Management, Medical Management, Finance Departments, and State Health Programs. If the prescribed three-step corrective action process with progressive sanctions does not resolve the deficiency, delegation may be revoked and the provider's contract terminated.

Coalition Reports

Program Accreditation Department
21281 Burbank Blvd., 5th Floor

Woodland Hills, CA 91367

Fax: 866-476-0311 provider.oversight@healthnet.com

Email the Delegation Oversight Group at Delegation_Oversight_Group@CENTENE.COM for any questions about access, users, or use of the Delegation Oversight Interactive Tool.

Health Net EDI Claims Department

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

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For questions on electronic claims or electronic remittance advice for Individual Family Plan (IFP), Medicare Advantage (MA) HMO member claims, contact:

Centene EDI Department

800-225-2573, extension 6075525

Or by email at EDIBA@centene.com

The following providers can continue to contact Health Net EDI department by phone at 800-977-3568 or by email at edi.support@healthnet.com

- California, MA HMO employer group, HMO, PPO (including EnhancedCare PPO for small business group), POS, and Medi-Cal (including CalViva Health)

Health Net Elect Claims

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

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Claims address for the Health Net Elect Point-of-Service (POS) product.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net Encounter Department

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

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Contact the Health Net Encounter Department via email for encounter data questions.

Enc_Group@healthnet.com

Health Net Enrollment Services Department

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

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For general questions regarding eligibility and enrollment, contact the Health Net Enrollment Services Department Monday through Friday, from 7:30 a.m. to 7 p.m. at:

800-327-0502

Health Net Facility Site Review Compliance Department

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

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The Health Net Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-on-one education and support of providers.

The Health Net FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staffs in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

21281 Burbank Blvd., Woodland Hills, CA 91367 209-943-4803
Email: Facility.site.review@healtlhnet.com

Health Net Fraud Hotline

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

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Health Net is serious about finding and reporting fraud, waste or abuse (FWA). To report suspected FWA, please contact the Special Investigations Unit at one of the following:

Phone: 866-685-8664. The toll-free Fraud, Waste & Abuse Hotline is answered by an independent third party and is available 24 hours a day, 7 days a week.

Email: Special_Investigations_Unit@centene.com

Mail: Centene Special Investigations Unit7700 Forsyth Blvd 5th floor, Room 519Clayton, MO 63105

Reports of suspected fraud may be made anonymously.

Health Net Health Education

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

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Medi-Cal Counties

Fresno, Kings, Madera

The Health Education System promotes resources and programs to educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

CalViva Health education programs, services and resources are available at no cost to CalViva Health Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting the Member Services at 888-893-1569. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

7625 N. Palm Suite #107 Fresno, CA 93721 888-893-1569
Fax: 800-628-2704

Amador, Calaveras, Imperial, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne

The Health Net Health Education educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

Health education programs, services and resources are available at no cost to the Plan's Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting Member Services at 800-675-6110. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

21281 Burbank Boulevard Woodland Hills, CA 91367 800-675-6110
Fax: 800-628-2704

Health Education programs and services include:

- Member Services Line. Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, and exercise. These materials are available in several threshold languages. Direct members to call their respective Member Services line.
- Tobacco Cessation Program. Kick It California is a no-cost, statewide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers:
    - **Telephonic Quit Coaching**:
        - Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
        - Tailored quit plan to member's unique circumstances.
        - Available Monday – Friday 7 a.m. – 9 p.m., Saturday 9 a.m. – 5 p.m.
        - To enroll, members may use the online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

        - **Automated Texting Program:**
            - Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within two business days.
            - Text "Quit Smoking" or "Quit Vaping" to 66819.
            - Texto "Deje de Fumar" o " No Vepear" al 66819.
        - **Chat with a Quit Coach**
            - Kickitca.org/chat
            - Alternative option for both members and health care providers.
            - Platform allows members quick responses to inquiries such as available services and free nicotine patch evaluation.
            - Health care providers may use the chat to find answers to cessation-related questions.
            - Available in English only, Monday – Friday, 7 a.m. – 9 p.m., and Saturday 9 a.m. – 5 p.m.
        - Mobile App:
            - Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
            - Features tools such as a personal log of smoking triggers, motivational reminders and links to helpful resources.
            - Available for download on the App Store® and Google Play®
            - Visit Kick It California for more details

- Digital Health Education - members have access to online and digital resources for health education through our Krames Staywell health library – Resource library to help you learn about your health and how to stay healthy.
  - Health and Medications – Easy access to more than 4,000 health sheets.
  - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.
- myStrength™ website and mobile application offers clinically-proven mental health resources to help members manage depression, anxiety, stress, substance use, and pain management.
- Health Education Classes. Members may access health education classes on a variety of health topics, such as diabetes, asthma, healthy eating, oral health, heart health, fitness, and prenatal care. Members can request a schedule of upcoming health education classes by calling their respective Member Services phone line.
- Member Incentive Programs - Incentive programs for members allow eligible individuals to engage in activities aimed at promoting behavioral change, such as health screenings, preventive health appointments, and health education initiatives, in exchange for rewards. Health Net will notify members who are eligible to participate.
- Provider Resources. Physicians may order health education materials online by using the Health Education Material Order Form.

21281 Burbank Boulevard Woodland Hills, CA 91367
Fax: 800-628-2704

Health Net Health Equity Department

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

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The Health Net Health Equity Department promotes access to care for members who speak a primary language other than English. The department is responsible for developing, implementing and monitoring processes to meet regulatory requirements. The department assesses the cultural and language needs of members and encourages provider, community advocate, and member input through ongoing communication and by participation in county-specific Community Advisory Committees. This helps ensure that materials and interpreter services are available in the member's language, while taking into consideration the member's cultural background in the development of member materials.

The Health Net Health Equity Department has a number of internal processes to enhance services to Health Net's non-English speaking members, including:

- Tracking the interpretation needs of members.
- Monitoring population and membership language distribution for trends.
- Monitoring the availability of materials translated into threshold languages.
- Assessment of language capabilities of the existing provider network and recommendations to the Health Net Provider Network Management staff for network development.
- Review of translations of member materials, such as the Evidence of Coverage (EOC), provider directories, marketing materials, form letters, health reminders, member surveys, newsletters, and health education materials.
- Providing in-service trainings, workshops and educational opportunities to Health Net staff on the linguistic needs and cultural background of Health Net members.

- Supporting Health Net participating providers with information and material on the cultural background, linguistic needs and health care concerns of Health Net members.
- Gathering feedback from providers, the community and members using surveys and focus group studies on cultural and linguistic needs.
- Monitoring and tracking cultural or linguistic related member grievances to gain an understanding of issues impeding member access to care.

Contact the Health Net Health Equity Department for more information at
Cultural.and.Linguistic.services@healthnet.com
Commercial: 800-977-6750
Medicare: 800-546-4570

Fax: 818-543-9188

For written translation assistance services, contact the appropriate Provider Services Center:

Line of Business	Phone Number	Hours of Availability
Large Employer Group	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (off exchange)	800-361-3366	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (on exchange)	888-926-5133	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (off exchange)	877-857-0701	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (on exchange)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays

Line of Business	Phone Number	Hours of Availability
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time
Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m. Pacific time
After hours Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110, select the member option	6 p.m. to 8 a.m. Pacific time, weekends and holidays
Medi-Cal/CalViva Health (Fresno, Kings and Madera)	888-893-1569	24 hours a day, 7 days a week
Medi-Cal/Community Health Plan of Imperial Valley	833-236-4141	24 hours a day, 7 days a week

Health Net Hospital Notification Unit

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

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Hospitals are required to contact the Health Net Hospital Notification Unit (HNU) within 24 hours of an admission (or one business day when an admission occurs on a weekend or holiday) for a Health Net member via phone, fax or website.

Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITES
• Employer group Medicare Advantage (MA) HMO • Employer group HMO, POS, PPO, (includes EnhancedCare PPO Small Business Group (SBG)) • Medi-Cal	Fax: 800-676-7969	provider.healthnetcalifornia.com
• Individual MA HMO and Special Needs Plan (SNP) (does not apply to MA HMO employer groups)	Fax: 844-825-8045	provider.healthnetcalifornia.com

For Individual & Family Plans (IFP) members (Ambetter HMO and Ambetter PPO), hospitals are required to contact the HNU within 24 hours or one business day, via fax or by web, when an admission occurs on a weekend.

IFP Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITE
• IFP Ambetter HMO • IFP Ambetter PPO	Fax: 844-760-8992	provider.healthnetcalifornia.com

Health Net
Attention: Hospital Notification Unit
21281 Burbank Blvd.
Woodland Hills, CA 91367

Post-stabilization authorization request: call 800-995-7890 to provide notification.

Health Net Long-Term Care Intake Line

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

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Providers should contact the Health Net Long-Term Care Intake line via fax to notify Health Net of its Medi-Cal members' admissions to long-term nursing facilities.

Fax: 855-851-4563

800-453-3033 - to check the status of your request

Health Net Mail Order Prescription Drug Program

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

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HMO and PPO

For commercial [non-Individual and Family Plan (IFP)] plans, use **CVS:**

New prescription medication requests may be mailed by the member or faxed to CVS by the prescribing physician. The member's identification number, date of birth, telephone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

CVS Caremark
PO Box 94467
Palatine IL 60094-4467
Fax: 800-378-0323

For on/off-exchange Ambetter HMO/PPO plans, use **Express Scripts® Pharmacy:**

The prescribing physician can send requests for new prescriptions to Express Scripts Pharmacy via **fax to 800-837-0959** or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx.

Medicare Advantage HMO

The prescribing physician can send requests for new prescriptions to **Express Scripts Pharmacy** via **fax to 800-837-0959** or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx. The member's identification number, date of birth, phone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

Note: For Employer Group Retiree Drug Subsidy (RDS) members, use CVS Caremark mail order service.

Health Net Marketing Department

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

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Prior to using, distributing or displaying marketing materials directed to Medicare-eligible beneficiaries, participating providers are required to send these materials for approval to the Health Net Marketing Department, Attention: Medicare Marketing Director.

MedicareMktgReview@healthnet.com

Health Net Medi-Cal Claims

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

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Address for written correspondence regarding claims, tracers, adjustment requests, or denial reconsideration. Health Net Community Solutions, Inc. Medi-Cal Claims PO Box 9020 Farmington, MO 63640-9020

Health Net Medi-Cal Facility Site Review Compliance Department

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

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The Health Net Medi-Cal Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-to-one provider education and support.

The Health Net Medi-Cal FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staffs in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

Fresno, Kings and Madera

7625 N Palm Ave., Ste. 101 Fresno, CA 93711 559-447-6114
Fax 877-779-0753

Amador, Calaveras, Imperial, Inyo, Kern, Los Angeles, Mono, Riverside, San Bernardino, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne

21281 Burbank Boulevard, 3rd Floor Woodland Hills, CA 91367 818-676-7860
Fax: 877-779-0753

Health Net Medi-Cal Medical Management Department

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

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The Health Net Medical Management Department conducts concurrent review of inpatient cases and coordinates care for members under the care management program. Contact the Prior Authorization Department to request prior authorization or assistance with referrals. Participating physician groups (PPGs) may contact the Medical Management Department for assistance with member case management. Providers affiliated with a delegated PPG must follow their PPG's instructions for referrals and requests for prior authorization. All participating providers must inform Health Net immediately when investigational or experimental treatment is requested.

Phone number for status of request: 800-421-8578
Fax: 800-743-1655

Medi-Cal Member Appeals and Grievances Department

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

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- By phone: Contact Health Net 24 hours a day, 7 days a week by calling 800-675-6110 or 833-236-4141(Imperial County). If you cannot hear or speak well, please call TTY: 711.
- In writing: Fill out an appeal form or write a letter and send it to:

Health Net Medi-Cal Member Appeals and Grievances Department P.O. Box 10348 Van Nuys, CA 91410-0348
Fax: 877-713-6189

Your doctor's office will have appeal forms available. Your health plan can also send a form to you.

- Electronically

OR

CalViva Health Member Appeals and Grievances Department PO Box 10348 Van Nuys, CA 91410-0348

Fax: 877-831-6019

Health Net Medi-Cal Member Services Department

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

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To ensure appropriate coverage of medical services for Medi-Cal members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, Health Net directs inquiries from members to Health Net's Medi-Cal Member Services Department. Provider inquiries are directed to the Provider Engagement Network Specialists when applicable.

The Health Net Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the Health Net Member Handbook and other member-informing materials are translated into the required threshold languages.

Health Net's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests.
- Handling complaints about Health Net programs or staff.

The Health Net toll-free number is printed on the back of the member's identification card 800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Health Net Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Health Net's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Health Net Nurse Advice Line (N24) when applicable.

Health Net Member Services Department Open 24/7

Phone Number: 800-675-6110

You can also visit Member Services online at any time at www.healthnet.com.

Fax: 844-837-5947 or 800-281-2999

Medi-Cal Provider Appeals and Grievances - Health Net Medi-Cal and CalViva Health

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

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Address for provider disputes and grievances:

Medi-Cal Provider Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

OR

CalViva Health Provider Disputes and Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

Health Net Medi-Cal Provider Services Department

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

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As a State Health Program, Health Net has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, Health Net directs inquiries from providers to Health Net's Medi-Cal Provider Services Department or to Health Net's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

Health Net's Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, seven days a week, to assist providers with:

- Member eligibility, effective dates and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the Plan’s Medi-Cal Rx Contract Drug List (CDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/PCP/PPG reassignment for non-compliant members

The Health Net Medi-Cal Provider Services Department toll-free telephone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Health Net Provider Services Department Phone Number: 800-675-6110, option 2
Fax: 844-837-5947 or 800-281-2999 Provider website

Providers may use HNMedi-cal.ClaimsInquiry@healthnet.com for claim status only if the provider portal is down or not working. This email is only for claim status and denial inquiries.

To disenroll a non-compliant member refer to Disenrollment section.

Fax or mail the formal letter and all supporting document’s to:

Attn: Non-Compliance Unit

Fax: (844) 837-5947

Address: PO BOX 10303, Van Nuys, CA 91410-0303

Health Net Medicare Advantage Claims Department

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

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Address for Health Net Medicare Advantage (MA) claims.

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

Health Net Medicare Advantage Provider Disputes

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

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Address for Medicare Advantage provider disputes.

Health Net Provider Appeals Unit
PO Box 9030
Farmington, MO 63640-9030

Health Net Medicare Appeals and Grievances Department

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

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Although there is a specific post office box for submission of Health Net Medicare member appeals for denied services or other grievance correspondence, Health Net prefers to receive appeals and grievances by fax. This

enables Health Net to receive, process and resolve the member's issues quickly in accordance with state and federal timeliness requirements. Member appeal requests must be submitted in writing.

Health Net Medicare Appeals and Grievances Department

Fax: 844-273-2671

PO Box 10450
Van Nuys, CA 91410-0450

800-275-4737

For non-contracted providers, submit your dispute request in writing, along with complete documentation (such as a remittance advice from a Medicare carrier), to support your payment dispute to:

Wellcare By Health Net – Appeals
P.O. Box 3060
Farmington, MO 63640-3822

Health Net Medicare Programs Provider Services Department

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

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To ensure appropriate coverage of medical services for Medicare members, Health Net requires the provision of timely responses and accurate information an absolute necessity. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this issue, Health Net directs inquiries from members and employer groups to the Medicare Programs Member Services Department. Inquiries from participating physician groups (PPGs), hospitals, ancillary providers, and physicians are directed to the Provider Services Department, or the provider relations and contracting specialist (previously known as regional network administrators), where available.

The Provider Services Department telephone number is to be used exclusively by PPGs, hospitals and providers and should not be given to members.

During business hours (Monday through Friday, 8 a.m. to 5 p.m.), Health Net Provider Services Department representatives are available to assist providers with:

- Member eligibility and effective dates, and eligibility research.
- Questions about the Health Net prescription drug program.
- Conflict resolution regarding benefit interpretation.
- Exceptions and administrative decisions.
- Complaints regarding health care services, delivery of health care services or PPG staff.
- Request for removal of members for disciplinary actions.

- PPG transfer requests, other than address change or open enrollment.
- Questions regarding claim status.

Claims address:

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

800-929-9224 for all Medicare individual and Medicare employer group plans

800-641-7761 for all Medicare Supplement plans

Health Net Member Appeals and Grievances Department

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

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Address and telephone numbers for member appeals for denied services or other grievance correspondence.

PO Box 10348

Van Nuys, CA 91410-0348

800-522-0088 for commercial members in Northern California

800-638-3889 for commercial members in Southern California

Fax: 877-831-6019

Health Net Member Services Department

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

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To ensure appropriate coverage of medical services for members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may unintentionally misuse the program, resulting in medical services not being covered. To avoid these problems, member and employer group inquiries are directed to an expert team of associates via the Health Net Member Services Department. This team is responsible for resolving member and employer group issues that have

been routed to them via a telephone call, written correspondence or the Internet. The Health Net Member Services Department is responsible for resolving issues pertaining to the following:

- Health Net benefit questions and explanations.
- Education on the access of the health care delivery system.
- Professional and hospital services, bills and claims.
- ChiroNet benefits and eligibility.
- Health Net prescription drug program questions, eligibility and claims.
- EyeMed Vision Care program questions about eyewear benefits, eligibility and claims.
- Membership problems and inquiries.
- Member updates (includes adding and deleting members, address changes, PCP/PPG changes).
- Contract cancellation requests.
- Conversion.
- Identification card requests.

Health Net Member Services Department
PO Box 9103
Van Nuys, CA 91409-9103
800-522-0088

Health Net Provider Communications Department

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

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The Health Net National Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, changes in contractual, legislative and regulatory requirements through provider operations manuals, updates, letters, and newsletters. To access the most current information, log on to the provider portal.

4191 East Commerce Way
Sacramento, CA 95834
Mailstop: CA4191-04-167

provider.communications@healthnet.com

Health Net Nurse Advice Line

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

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The Health Net Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour telephone service for instructions, medical condition assessment and advice. The Health Net Medi-Cal Member Services Department coordinates member access to the Health Net Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

800-675-6110

Health Net Overpayment Recovery Department

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

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Address for overpayment refunds and applicable information.

Health Net of California, Inc.
Attention: Claims Recover Team
PO Box 396027
San Francisco, CA 94139-6027

Health Net PPO Claims Submission

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

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Health Net Commercial Claims

PO Box 9040
Farmington, MO 63640-9040

Health Net – Prior Authorization Department

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

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Health Net accepts prior authorization requests for elective and urgent services by fax, phone and online. All participating providers must immediately inform Health Net when there is a request for investigational or experimental treatment.

Prior Auth Contacts

Lines of Business	Contact Numbers	Provider Portal Websites
• IFP Ambetter HMO	Fax: 844-694-9165 Phone: 888-926-2164 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• IFP Ambetter PPO	Fax: 844-694-9165 Phone: 844-463-8188 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Employer Group HMO, Point of Service (POS), PPO	Fax: 844-694-9165 Phone: 800-641-7761 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Health Net Medi-Cal • CalViva Health • Community Health Plan of Imperial Valley	Fax: 800-743-1655 • Health Net: 800-675-6110 • CalViva Health: 888-893-1569 • CHPIV: 833-236-4141 Transplant fax: 833-769-1141	provider.healthnetcalifornia.com

Lines of Business	Contact Numbers	Provider Portal Websites
• Medicare (Individual and Employer Group) and Special Needs Plan (SNP)	Fax: 844-501-5713 Phone: 800-929-9224 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com
• Medicare Supplement	Fax: 844-501-5713 Phone: 800-641-7761 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com

Mailing Address

Health Net
Attention: Prior Authorization Department
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Program Accreditation Department

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

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The Health Net Program Accreditation Department supports and promotes activities to assess and monitor organization-wide and provider compliance with regulatory and oversight bodies, including the California Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the California Managed Risk Medical Insurance Board (MRMIB). The department is also responsible for preparation and implementation of any identified actions based on the findings of DMHC, NCQA and CMS audits.

The Program Accreditation Department collects, reviews and assesses various required submissions from delegated participating physician groups (PPGs), including financial statements and utilization management reports.

Address to submit expedited organization determination (EOD), Notice of Medicare Non-Coverage (NOMNC) tracking logs, utilization management and financial reports:

Program Accreditation Department Compliance Analyst
21281 Burbank Blvd.
Woodland Hills, CA 91367

818-676-6704

Provider Oversight efax: 877-890-4105

UMQIMR@healthnet.com

Health Net Provider Services Center

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

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The Health Net Provider Services Center is available to physicians, participating physician groups (PPGs), hospitals, and other providers, and features live customer service representatives, an interactive voice response (IVR) system and the provider portal websites. Customer service representatives are available via telephone and online during business hours (Monday through Friday, 8:00 a.m. to 6:00 p.m.). Services provided include the following:

- Member eligibility and effective dates information.
- Health Net's prescription drug program information.
- Claims status information.
- Instructions on how to submit disputes and appeals.
- Instructions on how to submit a complaint regarding the provision of care by a provider or express concerns about provider office staff.
- Instructions on how to request the removal of members for disciplinary actions.
- Information about the provider portal websites.

IVR for Employer Group HMO and PPO members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member eligibility and claim information without waiting to speak with a Provider Services Center representative. For employer group HMO and PPO members, providers may contact 800-641-7761. The IVR includes:

- Current and past eligibility status.
- Benefits information.
- Single or multiple claims status.
- Claims submission addresses.
- Automated fax back of member eligibility and claim status information.

IVR for Covered California and Individual Family Plan (IFP) members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member The following IVRs are available for Covered California and IFP members, which include CommunityCare HMO and

PPO Individual and Family members (EnhancedCare PPO members are excluded). Providers may verify or check eligibility status by member name and plan, claims status and copayment information.

IFP IVR Phone Numbers

If...	Then contact Health Net at...	And...
Covered California appears on the member identification (ID) card	888-926-2164 for Covered California Health Net members	Follow the prompts
Covered California does not appear on the member (ID) card	877-857-0701for Health Net IFP members	Follow the prompts

Provider Services Center Contact Information

Line of Business	Phone Number	Provider Portal Website
• EnhancedCare PPO (IFP)	844-463-8188	provider.healthnetcalifornia.com
• EnhancedCare PPO (SBG)	844-463-8188	provider.healthnetcalifornia.com
Health Net Employer Group HMO, POS, and PPO	800-641-7761	provider.healthnetcalifornia.com
• Individual Family Plan (includes CommunityCare HMO and PPO Individual and Family)	888-926-2164	provider.healthnetcalifornia.com

Claims Address

Health Net Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Email Address

provider_services@healthnet.com

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

Health Net Quality Improvement Department

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

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Contact Health Net's Quality Improvement Department for questions regarding quality improvement projects (QIPs).

For commercial providers email:
cqi_dsm@healthnet.com

For Medicare providers email:
cqi_medicare@healthnet.com

Health Net's Regional Medical Directors

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

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To provide better service to participating physician groups (PPGs), hospitals, employer groups, and members, Health Net's regional medical directors are located in the Irvine, Oakland, Rancho Cordova, San Diego, Woodland Hills, and other regional offices. Health Net's regional medical directors are directly responsible for any clinical matters related to Health Net policies and procedures. They also serve as professional consultants to the PPGs and hospitals.

Health Net's regional medical directors work closely with PPGs and hospitals to monitor, manage and achieve greater efficiency in the following areas:

- Utilization management (UM), including care management
- Quality management
- Pharmaceutical management
- Case review or member complaints relating to quality of care and access
- Introduction of new products

Health Net Third-Party Liability Department

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

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Medi-Cal

Providers must notify Health Net or the participating physician group (PPG) in writing of all potential and confirmed third-party tort liability cases involving a Health Net Medi-Cal member. Notify Health Net if a provider receives any subpoenas from attorneys, insurers or beneficiaries for copies of bills. Supply Health Net with copies of the request and copies of documents released as a result of the request, and provide the name, address and telephone number of the requesting party. The notification must be submitted via email to or mail notifications to:

Health Net TPL Recovery TPL Department Mailstop: CA-4191-04-108 4191 East Commerce Way Sacramento, CA 95834

Health Net Transfer/Termination Request Unit

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

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Participating physician groups (PPGs) considering the termination of a Health Net member must submit a Transfer/Termination (T/T) Incident Report to the Health Net Transfer/Termination Request Unit.

HMO

T/T Requests
P.O. Box 10348
Van Nuys, CA 91410
Fax: 877-831-6019

Medicare Advantage HMO

T/T Requests

Medicare Services:
Health Net Appeals and Grievances Department
P.O. Box 10344
Van Nuys, CA 91410-0344
Fax: 877-713-6189

Health Net Transplant Care Manager

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

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Submit transplant information to Health Net. Health Net reviews the request and may advise the participating physician group (PPG) or provider to refer the member to a transplant performance center for evaluation. Health Net's designated transplant performance centers are Medicare-certified. On completion of any evaluation, the transplant performance center must fax the evaluation directly to the Health Net transplant care manager.
888-732-2730
Fax: 866-292-5294

Health Net Transportation Vendors

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

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- Medi-Cal: ModivCare – Members can call Where's My Ride? at 855-253-6863, TTY: 711.
- Medicare: Access2Care – Medicare members can call 844-515-6876.

Health Net Utilization Management Department

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

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Health Net's Utilization Management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are the elements of the UM process.

Health Net Utilization Management Department
PO Box 10198
Van Nuys, CA 91410

Health Net Wellness and Prevention Department

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

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Contact the Health Net Wellness and Prevention Department at:

916-935-1263

Hearing Care Solutions

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

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866-344-7756
Monday through Friday
5 a.m.-5 p.m. PT

For more information, visit the Hearing Care Solutions website.

Hearing Healthcare Providers

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

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Hearing Healthcare Providers (HHP)

www.hhpca.org

HNI Corporate Address

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

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If a participating physician group (PPG) needs to request a change to the information currently in their Provider Participation Agreement (PPA), the request must be made in writing and sent to:

Health Net of California, Inc.
Attention: Vice President, Provider Contracting/Provider Network Management
21281 Burbank Blvd
Woodland Hills, CA 91367

Hoveround Inc

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

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Provider of custom rehabilitation equipment services.

800-701-5781

In-Home Operations

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

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Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment, and those at risk of life-threatening occurrences, requires close coordination between Health Net and the Home and Community-Based Services (HCBS) Waiver program administered by In-Home Operations (IHO). This program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met by providing in-home care. 916-552-9105 in Northern California
213-897-6774 in Southern California
email: IHOwaiver@dhcs.ca.gov

J&B Medical Supply Company Inc

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

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J&B Medical Supply Company, Inc. Address: 50496 W. Pontiac Trail, Wixom, MI 48393-2088 Phone: 800-737-0045
Fax: 800-737-0012 Website: www.jandbmedicalinsurance.com

Kick It California

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

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800-300-8086 (English)

800-600-8191 (Spanish)

kickitca.org

LabCorp

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

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To find a LabCorp center near you or request a pick-up, visit www.LabCorp.com or call 800-244-9698.

Linkia LLC

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

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Linkia, LLC is Health Net's preferred provider for orthotics and prosthetics.

877-754-6542

Livante (California Quality Improvement Organization (QIO)

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

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Livante
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolise Junction, MD 20701

Phone: 877-588-1123 or TTY: 855-887-6668
Appeals fax: 855-694-2929
All other reviews fax: 844-420-6672

Los Angeles Department Of Public Social Services

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

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Providers may call the Los Angeles Department of Public Social Services (DPSS) for assistance with the In-Home Supportive Services (IHSS) program.

The IHSS program provides services to seniors and persons with disabilities allowing them to remain safely in their homes.

888-944-4477 213-744-4477

Mahmee

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

Mahmee offers virtual doula services via the Mahmee mobile app that is designed to better connect new moms with health care and support. Mahmee can be contacted at the number listed below:

818-431-1118

Monday through Friday from 6 a.m. to 8 p.m. PT.

Saturday and Sunday from 8 a.m. to 6 p.m. PT.

Managed Care Ombudsman

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

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The Department of Health Care Services (DHCS) Managed Care Ombudsman investigates and attempts to resolve complaints about managed care plans that members have been unable to resolve through their health plans. 888-452-8609

March Vision Care

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

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Health Net members assigned to Molina Healthcare may contact March Vision Care to locate a participating optometrist and optician from whom to order and receive lenses and frames.

888-493-4070

Matria Health Care Inc

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

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Matria Health Care, Inc. provides home health and infusion services to high-risk obstetric members.

800-289-7744

Medical Board Of California

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

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A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to members. For a no-cost brochure, contact the Medical Board of California, Breast Cancer Treatment Options. Breast Cancer Treatment Options 1426 Howe Avenue, Suite #54 Sacramento, CA 95825 Fax: 916-263-2479

Medi-Cal Provider Contested Claims

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

Address for provider contested claims:

Health Net Medi-Cal Contested Claims Department PO Box 989736 West Sacramento, CA 95798

OR

CalViva Health Contested Claims Department PO Box 989736 West Sacramento, CA 95798

Medi-Cal Rx CSC

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

Medi-Cal Rx

Phone: 800-977-2273 Fax 800-869-4325

Appeals
Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 730 Rancho Cordova, CA, 95741-0730

Prior authorization
Medi-Cal Rx Customer Service Center Attn: PA Request PO Box 730 Sacramento, CA 95741-0730 Phone: 800-977-2273

Medicare Appeals Council

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

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Health Net Medicare Advantage (MA) and MA members may request that the Medicare Appeals Council (MAC) review an administrative law judge (ALJ) decision. The review request must be made within 60 days from the date Health Net receives the ALJ hearing decision or dismissal. The request for appeal may be submitted directly to the MAC.

Department of Health and Human Services
Department Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

Member Rights Information

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

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This insert must be customized with the health plan and/or participating physician group (PPG)-specific phone number and applicable couty-specific phone number for the applicable legal services office.

Legal Services Offices for Assistance for Medi-Cal Managed Care Enrollees

COUNTY	LEGAL SERVICES OFFICE
Fresno	Central California Legal Services - 800-675-8001
Kern	Greater Bakersfield Legal Aid - 661-321-3982
Kings	Central California Legal Services - 800-675-8001
Los Angeles	Neighborhood Legal Services - 800-896-3203
Madera	Central California Legal Services - 800-675-8001
Orange	Legal Aid Society of Orange County - 800-834-5001

COUNTY	LEGAL SERVICES OFFICE
Riverside	Inland Counties Legal Services Indio Office - 800-226-4257 Riverside Office - 888-455-4257
Sacramento	Legal Services of Northern California - 888-354-4474
San Bernardino	Inland Counties Legal Services San Bernardino - 800-677-4257 Rancho Cucamonga - 800-977-4257
San Joaquin	Legal Services of Northern California - 888-354-4474
San Diego	Legal Aid Society of San Diego - 877-734-3258
Stanislaus	Central California Legal Assistance - 800-675-8001
Tulare	Central California Legal Services, Visalia Office - 800-350-3654

MHN Customer Service Department

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

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If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or his or her staff may contact the MHN Customer Service Department for a referral to an MHN provider. Customer service specialists may also assist with member eligibility, benefits and general questions about MHN.

888-935-5966

Providers treating CalViva Health members: 888-327-0010

MiniMed Distribution Corp Inc

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

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MiniMed Distribution Corp, Inc. provides insulin pumps and supplies to members with diabetes.

800-795-0618
Fax: 800-611-1716

Modivcare

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

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HMO

Non-emergency transportation services are arranged through Modivcare™ 24 hours a day, 7 days a week.

For HMO:

866-842-0675
Fax: 800-762-1777

HMO

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week

Medi-Cal

Refer to the table below to arrange for transportation services through Modivcare. Modivcare uses language-line interpreter services for all interpretation needs during reservations.

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Standard days and hours of customer service center operation for routine reservations.	Monday through Friday, 7 a.m. to 7 p.m. Pacific time.
Weekend and holiday schedule	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas
Routine transportation requests	- Rideshare curb-to-curb in “real time”. (For avoidance of doubt, “real time” is defined as within 1 hour of member request.) - Non-rideshare curb-to-curb 24 hours in advance (sedan, taxi) - 48-hour notice for any mode of transportation higher than sedan (wheelchair [including ambulatory door-to-door], stretcher, non-emergent ambulance)
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for the same day of service for hospital discharges and urgent treatment types. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance (Where's my Ride? line) and hospital discharges	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week

Modivcare Contact Information

FORM OF CONTACT	CONTACT INFORMATION
Toll-free telephone numbers	**Submit a Physician Certification Statement (PCS) form to the Health Net Care Ride Unit to obtain authorization before contacting Modivcare for scheduling.** Reservations and ride assistance (Where's My Ride? line) for Medi-Cal members: 855-253-6863 Ride assistance (Where's My Ride? line) for CalViva Health members: 855-253-6864 Ride assistance (Where's My Ride? line) for CHPIV members: 855-251-7097 Hearing impaired (TTY) line: 866-288-3133 For providers: Facility line: 866-529-2128 Facility fax: 877-601-0535
Website	Modivcare.com Providers may use the Modivcare website to schedule only routine transports with an advance notice of 5 business days. Print an enrollment form from the Modivcare website to sign up for this HIPAA-compliant service and return it by fax to 877-601-0535.

Molina Behavioral Health Services

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

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Behavioral Health Services assists providers with mental health services for Molina members.

1-888-665-4621
Fax: 1-866-472-0596

Molina Claims Department

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

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Submit written correspondence or claims, tracers, appeals, or adjustments to the Molina Healthcare Claims Department.

Molina Healthcare Claims PO Box 22702 Long Beach, CA 90801 1-888-665-4621, press 1 for provider

Molina Credentialing And Facility Site Review Department

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

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The Molina Healthcare Credentialing Department verifies all information about each Molina provider and evaluates the applicant's qualifications to be credentialed or recredentialed. Recredentialing of providers is conducted at least every three years. Credentialing: 1-800-526-8196 ext. 120117
Fax: 1-888-665-4629

Facility Site Review 1-800-526-8196 ext. 120118
Fax: (562) 499-6185

Molina Encounter Department

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

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The Molina Encounter Department handles all claims for capitated services.

P.O. Box 22807 Long Beach, CA 90801 MHCEncounterDepartment@MolinaHealthCare.com

Molina Healthcare Education Department

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

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The Molina Healthcare Education Department improves the health outcomes of Medi-Cal members through member and provider education and facilitating provider access to member education resources and information.

1-866-472-9483

Molina Healthcare Provider Resolution Department

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

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The Molina Healthcare Provider Resolution Department handles written inquiries from providers regarding claim disputes. Written inquiries should be sent to the following address.

Molina Healthcare Attn: Provider Dispute Unit PO Box 22722 Long Beach, CA 90801 Fax: (562) 499-0633

Molina Interactive Voice Response

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

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Contact the Molina Interactive Voice Response system if a member arrives at a primary care physician (PCP) office to receive care and does not appear on the current month's eligibility listing. 1-800-357-0172

Molina Member Services

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

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Molina Healthcare offers telephonic services via telephone. 1-888-665-4621

Molina Nurse Advice Line

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

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Molina&s nurse advice line is staffed 24 hours a day, seven days a week by highly trained nurses for member assistance and referrals. 1-888-275-8750 (English)
1-866-648-3537 (Spanish)

Molina Pharmacy Department

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

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The Molina Healthcare Pharmacy Authorization Desk is responsible for Molina's medication prior authorization requests.

1-888-665-4621, press 1 for provider
Fax: 1-866-508-6445

Molina PM160 INF Forms

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

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Send completed PM160 Information Only (INF) forms to Molina Healthcare via the fax below. (562) 435-3666, ext. 127350
Fax: (562) 499-6193

Molina Provider Services Department

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

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For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. The Molina Healthcare Provider Services Department is the provider liaison to the health plan's administrative programs. This department handles telephone and written inquiries from providers regarding contracting, capitation verification, scheduling of in-service training, site audit status, and credentialing information.

200 Oceangate, Ste. 100 Long Beach, CA 90802 1-855-322-4075
Fax: 1-855-278-0312 www.molinahealthcare.com

Molina Quality Improvement Department

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

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The Molina Quality Improvement Department reviews member medical records, population-based studies on preventive care, clinical practice guidelines, focused studies, member and provider satisfaction studies, complaints and grievances, and monitors continuing quality improvement. 1-800-526-8196, ext. 126137
Fax: (562) 499-6185

Molina Utilization Management Department

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

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The Molina Healthcare Utilization Management Department handles referrals and prior authorization requests, conducts concurrent review on inpatient cases, and coordinates care for members under the case management program, including California Children's Services (CCS).

Outpatient and urgent referral requests: 1-800-526-8196, option3, then option 4

Inpatient referral requests: 1-800-526-8196, option3, then option 4

CCS referral requests: 1-888-562-5442, ext. 126586

Case management referral requests: 1-800-526-8196, ext. 127604
Fax: (562) 499-6105

Outpatient and prior authorization requests: Fax: 1-800-811-4804

Notification of inpatient admissions: Fax: 1-866-553-9262

Notification of concurrent review: Fax: 1-866-553-9263

Multipurpose Senior Services

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

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The Multipurpose Senior Services Program (MSSP) Waiver Program assists frail members ages 65 and older in remaining safe in their homes. The program is administered by the Department of Aging and provides a cost-effective alternative to institutionalization while assisting seniors in maintaining important ties to family, friends and the community. A Health Net member who meets the criteria for MSSP services and is approved and accepted into the waiver program is disenrolled from Health Net and becomes eligible for the Medi-Cal fee-for-service (FFS) program.

Amador, Calaveras, Tuolumne

Area 12 Agency on Aging
19074 Standard Road Sonora, CA 95370 209-532-6272
Fax: 209-532-6501

health net

Fresno, Madera

Fresno and Madera Agency on Aging 3837 N. Clark Street Fresno, CA 93726 (559) 453-4405

Imperial

Imperial County Work Training Center, Inc. 210 Wake Avenue El Centro, CA 92243 760-352-6181
Fax: 760-352-6332

Inyo, Mono

Eastern Sierra Area Agency on Aging
1360 North Main Street, Suite 201 Bishop, CA 93514-2709 760-873-3305
Fax: 760-878-0266

Kings, Tulare

Kings and Tulare Area Agency on Aging 5957 S. Mooney Boulevard Visalia, CA 93277 (559) 737-4660
(800) 321-2462

San Joaquin

San Joaquin County Human Services Agency - Aging & Community Services Bureau 102 S. San Joaquin Street Stockton, CA 95202 (209) 468-1104
Fax (209) 932-2613

Stanislaus

Stanislaus County Community Services Agency 251 East Hackett Road Modesto, CA 95353 (209) 558-2346
Fax: (209) 558-2681

National Seating And Mobility

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

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Provider of custom rehabilitation equipment services.

800-404-6676

Nurse Advice Line

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

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HMO and PPO

Health Net's Nurse Advice Line is a telephonic support program that empowers members to better manage their health. The Nurse Advice Line offers support for members coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained registered nurses (health information managers) are available 24 hours a day, seven days a week.

The Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Nurses provide one-on-one consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the nurse advice line by calling the member services number on the back of their identification (ID) card.

The Nurse Advice Line is available to physicians to discuss concerns or make referrals at 800-893-5597; select the physician/provider options.

Medicare Advantage HMO

Contact the Nurse Advice Line at 800-893-5597

Peer-to-Peer Review Request Line

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To request a peer-to-peer review, call the applicable Peer-to-Peer Review Request Line below with the necessary information available.

If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Plan or product	Phone number	Required information

Individual & Family Plans (Ambetter HMO and PPO) Employer Group (HMO/POS, PPO) Medicare Advantage HMO and PPO	818-676-7371	• Member name • Member date of birth • Case number • Medical director name • Name of the nurse who worked the case • Member identification number
Medi-Cal	818-676-5503	
CalViva Health		
Community Health Plan of Imperial Valley		

Pharmacy Services

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

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HMO and PPO

Providers must contact Pharmacy Services by telephone, fax or mail to request prior authorization for certain prescription medications before medications are dispensed.

800-548-5524, option 3
Fax: 866-399-0929

MedPharm
Attention: Prior Authorization
4191 East Commerce Way
Sacramento, CA 95834-9679
Mailstop: CA4151-04-530

Medi-Cal

Pharmacy Services is responsible for review of requests for medical benefit medication prior authorization for Health Net Medi-Cal members.

MedPharm
Attention: Prior Authorization
4191 East Commerce Way Sacramento, CA 95834-9679
Mailstop: CA4151-04-530 800-867-6564

Fax: 833-953-3436

Medicare Advantage HMO

Providers must contact Pharmacy Services by telephone, fax or mail to request prior authorization for certain prescription medications before medications are dispensed.

800-867-6564
Fax: 800-977-8226

MedPharm
Prior Authorization
4191 East Commerce Way
Sacramento, CA 95834-9679
Mailstop: CA4151-04-530

Premier Eye Care

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

Premier Eye Care

833-883-2339

Monday – Friday, 8 a.m. – 8 p.m. Pacific time

Email: info@premiereyecare.net

Provider Disputes and Appeals - Commercial

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

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Address for provider disputes and appeals:
Health Net Commercial Provider Disputes

PO Box 9040
Farmington, MO 63640-9040

Provider Network Management Department

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

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The Provider Network Management (PNM) Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

HMO, Medicare Advantage HMO, Medicare Supplement, and PPO

If you need additional information, contact the Provider Services Department (HMO, PPO, and Medicare Advantage HMO, and Medicare Supplement) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For hospitals and PPGs, if you need further assistance you may contact your regional provider network manager or provider network administrator.

Medi-Cal

If you need additional information, contact the Provider Services Department (Health Net, CalViva Health or Community Health Plan of Imperial Valley) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For hospitals and PPGs, if you need further assistance you may contact your regional provider network manager or provider network administrator.

Provider Network Management, Access and Availability Team

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

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Email: Provider Network Management, Access and Availability Team for more information.

Provider Relations Department

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

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The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.

Email: The Provider Relations Department

Pumping Essentials

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

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Health Net's preferred breast pump provider.

866-688-4203

Quest Diagnostics

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

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For information about Quest Diagnostics laboratory testing solutions and services or to set up an account, call 866-697-8378.

To locate a Quest Diagnostics Patient Service Center (PSC), or schedule a PSC appointment for a Health Net member, log on to the Quest Diagnostics website or call 888-277-8772.

Regional Centers

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

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Regional centers are private, non-profit corporations under contract with the California Department of Developmental Services (DDS). Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidence of developmental disabilities. Below are the regional centers as indicated for each county:

Amador, Calaveras and Tuolumne

Valley Mountain Regional Center
702 North Aurora Street Stockton, CA 95202 209-473-0951
Fax: 209-473-0256

Fresno, Kings, Madera, and Tulare

Central Valley Regional Center 4615 North Marty Ave. Fresno, CA 93722 559-276-4300
Fax: (559) 276-4360

Imperial

San Diego Regional Center 4355 Ruffin Road, Suite 200 San Diego, CA 92123-1648 858-576-2996
Fax: 858-576-2873

Inyo, Kern and Mono

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93308 661-327-8531
Fax: 661-324-5060

Kern

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93305 661-327-8531

Los Angeles

Eastern Los Angeles Regional Center 1000 South Fremont Ave., PO Box 7916, Alhambra, CA 91802-4700 626-299-4700

Frank D. Lanterman Regional Center 3303 Wilshire Blvd., Ste. 700, Los Angeles, CA 90010-2197 213-383-1300

Harbor Regional Center 21231 Hawthorne Blvd., Torrance, CA 90503 310-540-1711

North Los Angeles Regional Center 15400 Sherman Way, Ste. 170, Van Nuys, CA 91406 818-778-1900

San Gabriel/Pomona Regional Center 75 Rancho Camino Dr., Pomona, CA 91766 909-620-7722

South Central Los Angeles Regional Center 650 W. Adams Blvd., Ste. 200, Los Angeles, CA 90007 213-744-7000

Westside Regional Center 5901 Green Valley Circle, Ste. 320, Culver City, CA 90230-1024 310-258-4000

Sacramento

Alta California Regional Center 2241 Harvard St., Sacramento, CA 95815 916-978-6400
Fax: (916) 929-1036

San Diego

San Diego Regional Center for the Developmentally Disabled 4355 Ruffin Rd., Ste. 200, San Diego, CA 92123-1648 858-576-2931

San Joaquin and Stanislaus

Valley Mountain Regional Center 702 N. Aurora St., Stockton, CA 95202 209-473-0951
Fax: (209) 473-0256

Reinsurance Claims Unit

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

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Insured service claims should be sent to:

Reinsurance Claims Unit/LNR - C3
Attn: Mail Code - CA-100-03-02
21281 Burbank Blvd.
Woodland Hills, CA 91367

River City Medical Group

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

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River City Medical Group (RCMG) members may contact RCMG to locate a participating optometrist and optician from whom to order and receive lenses and frames.

800-928-1201

Roche

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

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Provider of insulin pumps and supplies to members with diabetes.

800-280-7801

San Diego County Aging and Independence Services

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

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The San Diego County Aging and Independence Services (AIS) provides services to seniors and persons with disabilities and their family members allowing them to remain safely in their homes.

Providers can call the San Diego County AIS for assistance with In-Home Supportive Services (IHSS) or the Multipurpose Senior Services Program (MSSP).

800-510-2020

San Francisco Medi-Cal Field Office

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

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Except for kidney transplants, major organ transplant authorization requests for Medi-Cal members age 21 and over must be sent to the San Francisco Medi-Cal Field Office. 575 Market Street, Suite 400 San Francisco, Ca 94105 415-904-9600

Mailing address: P.O. Box 193704 San Francisco, CA 94119

SilverSneakers Program

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

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Health Net contracts with American Specialty Health Fitness, Inc. to administer and arrange a fitness service for Health Net members in accordance with the member's applicable benefits plan. Refer members to the Silver&Fit® website for more information.

Smiths Medical Inc

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

Back to previous page

Provider of insulin pumps and supplies.

800-826-9703

Solutran

Multi-Benefit Spendables Card

Wellcare By Health Net Dual Special Needs Plan (D-SNP) offer members extra benefits at no cost. Included in the plan, members have an over-the-counter (OTC) benefit where they will receive a fixed dollar monthly allowance amount preloaded into their Wellcare Spendables Card. The monthly allowance rolls over to the following month if unused and expires at the end of the plan year.

Members may use the Wellcare Spendables Card OTC dollars to purchase everyday items like bandages, pain relievers, cold remedies, toothpaste and much more. The card can be used on any combination of the following:

- Over-the-counter items such as cold medicine, first aid supplies, and vitamins.
- Buy groceries.
- Pay for utilities such as electric, gas, trash, water, internet, cable, and phone service.
- Help with the cost of rent for their home.
- Pay for gas at the pump (cannot be used to pay in person at the cash register).

Note:

- Any unused funds will roll over to the next month and will expire at the end of the year.
- The card cannot be used to set up automated, recurring payments.
- The care can only be used up to the available allowance amount.
- The card is similar to a debit card. Members can use their card to pay for eligible items and services at participating retail location or order online that accept Visa.

For more information about this benefit, members may contact Solutran.

855-744-8550
April-September
Monday through Friday
5 a.m.-8 p.m. Pacific time (PT)

October-March
7 days a week
5 a.m.-8 p.m. PT

For more information, visit secure member website.

Sonus

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

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888-383-4521

SONUS

Special Supplemental Nutrition Program For WIC

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

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The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition education and specific foods for women, infants and children from families with low incomes. WIC is temporary and provides supplemental food and nutrition education for a limited time during critical periods of growth and development.

Amador

430 Sutter Hill Rd. Sutter Creek, CA 95685 209-223-7685

Calaveras

209-223-7685

Fresno

Special Supplemental Nutrition Program

Location	Phone Number
Fresno Economic Opportunity Commission	559-263-1150
Huron WIC Clinic	559-945-5090
Kerman WIC Clinic	559-846-6681
Mendota	888-638-7177
Orange Grove	888-638-7177
Parlier WIC Clinic	888-638-7177
Reedley WIC Clinic	888-638-7177
Sanger WIC Clinic	888-638-7177
Selma WIC Clinic	888-638-7177

Imperial

2600 Thomas Dr. El Centro, CA 92243 877-686-5468
Fax: 760-353-2555

Inyo

760-872-1885

Kern

Community Action Partnership 500 E. California Bakersfield, CA 93307 661-327-3074
Fax: (661) 327-2833

Clinica Sierra Vista - WIC Administrative Office 1430 Truxtun Avenue, Suite 300 Bakersfield, CA 93301
661-862-5422
661-326-6490
800-707-4401
Fax: (661) 322-1418

Kings

Special Supplemental Nutrition Program

Location	Phone Number
Hanford, Lemoore, Avenal, Corcoran, Kettleman	559-582-0180

Los Angeles

Special Supplemental Nutrition Program

Location	Phone Number
Antelope Valley Hospital	661-949-5805
Harbor - UCLA Research and Education Institute	310-661-3080
Long Beach	562-570-4242
Northeast Valley Health	818-361-7541 800-942-9675
Orange County Health Care	714-834-8333
Pasadena	626-744-6520
Public Health Foundation Enterprises	888-942-2229 626-856-6600
Watts Health Foundation	323-568-3070

Madera

Special Supplemental Nutrition Program

Location	Phone Number
Madera	559-675-7623
Oakhurst	559-658-7456
Chowchilla	559-201-5000

Mono

760-924-4610

Sacramento

Community Resource Project WIC Program 915 Broadway Sacramento, CA 95818 916-326-5830

Sacramento County Department of Health and Human Services 2251 Florin Road, Suite 100 Sacramento, CA 95822 916-427-5500

San Diego

Special Supplemental Nutrition Program

Location	Telephone Number
American Red Cross WIC	800-500-6411
North County Health Services	Appointment line: 888-477-6333 or 760-471-2743
San Diego State University Foundation	Client Call Center: 888-999-6897
San Ysidro Health Center	Appointment line: 619-426-7966

San Joaquin

San Joaquin County Public Health Services 1145 N Hunter Street Stockton, CA 95202 209-468-3281
Fax 209-468-8573

Stanislaus

Stanislaus County Health Services WIC Program 401 Building E. Paradise Road Modesto, CA 95351
209-558-7377
Fax: 209-558-8318

Tulare

New WIC appointments and client line: 800-360-8840
559-685-2521

Porterville Clinic 1055 West Henderson, Suite 5 Porterville, CA 93257 559-788-1323

Tuolumne

209-533-7434

State Hearing Division

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

Members can ask for a State Hearing in the following ways:

- Online
- By phone:
  - 800-743-8525.
  - TTY/TDD 800-952-8349.
- In writing:
  - Members should fill out a State Hearing form or write a letter. Send it by mail or fax to: Mail: California Department of Social Services

State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430 Fax:
916-309-3487 or toll-free at 833-281-0903

Teladoc Health

Wellcare By Health Net (Health Net) has partnered with Teladoc Health™ (Teladoc) to give members access to telehealth care at no additional cost. Telehealth, or virtual care, allows members to interact with a doctor, nurse or therapist by phone or video without leaving the comfort and safety of their home for many healthcare services.

Teladoc Health offers convenient telehealth services for members. Through Teladoc Health, members can get confidential access to virtual visits with quality doctors and behavioral health providers. Members can schedule a visit with one of Teladoc Health's U.S. board-certified doctors and behavioral health providers, they can be diagnosed, treated and prescribed medication if medically necessary.

Members can use their telehealth benefit for:

- Non-emergency care from in-network providers using their home phone, laptop, table, or smartphone to connect for a video call.
- Speak to a Nurse 24/7: Get answers to health questions and find out if they need to see a doctor or urgent care center.
- Book a phone or video appointment.

Telehealth services with in-network providers work just like face-to-face in office appointments. Telehealth visits do not require a prior authorization. Plan copays, coinsurance and deductible costs may apply. Members may refer to their plan Summary of Benefits for coverage.

To preregister for Teladoc services, visit Teladoc Health.

800-835-2362 Available 24 hours a day, 7 days a week

Tuberculosis Control Program

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

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Tuberculosis (TB) screening and treatment services for Health Net Medi-Cal members are covered by Health Net under the Department of Health Services (DHS) contract. Health Net collaborates with local health departments (LHDs) to control the spread of TB and to help members get TB treatment. Health Net coordinates with LHDs to establish effective coordination of care. Early diagnosis, immediate reporting to LHDs, and effective TB treatment are critical to interrupting continued transmission of TB. Physicians must report known or suspected cases to the LHD TB Control program office within one day of identification.

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3434
Fax: 559-445-3598

Kern

Department of Public Health Services Chronic Disease Prevention Program 1800 Mt. Vernon Avenue
Bakersfield, CA 93306 661-321-3000

Kings

Kings County Department of Public Health Communicable Disease Services 1400 West Lacey Boulevard
Hanford, CA 93230 559- 584-1401 ext. 2741

Madera

Madera County Public Health Department Communicable Disease Control Program 14215 Road 28 Madera,
CA 93638 559-675-7893
Fax: 559-674-7262

Sacramento

Sacramento County DHHS, Chest Clinic Paul F Hom Primary Care Center 4600 Broadway, Room 1300
Sacramento, CA 95820 916-874-9823
Fax: 916-874-9442

San Diego

Tuberculosis (TB) Control Program 619-540-0194

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3828
Fax 209-468-8222

Stanislaus

Stanislaus County Health Services Agency 209-558-7700
Fax: 209-558-5014

Tulare

Tulare County Department of Health Services 559-685-2275
Fax: 559-685-4786

Transitional Care Services

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

The Transitional Care Services (TCS) program ensures a smooth transition from one setting to another and reduces re-hospitalization risks and other potentially adverse events. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post-discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post-discharge stay is essential in navigating the health care continuum and addressing barriers to post-discharge success for the member.

Members can call the Transitional Care Services toll free line anytime during their inpatient stay or after their discharge to request TCS support 866-801-6294.

Providers are encouraged to refer members not inpatient to the Complex Case Management Program.

Transplant Team

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

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Transplant Team

Fax: 833-769-1141

TurningPoint Healthcare Solutions, LLC

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

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TurningPoint Healthcare Solutions, LLC is responsible for prior authorization for:

- Certain inpatient and outpatient musculoskeletal surgical procedures for HMO, POS, HSP, EPO, PPO (Commercial) and Medi-Cal lines of business.
- Cardiovascular and ear, nose and throat (ENT) for Commercial lines of business.

TurningPoint Contacts

Phone: 855-332-5898

Fax: 949-774-2254

Email: centenecaum@turningpoint-healthcare.com

Website: MyTurningPoint

Training: Email provider support or contact TurningPoint by telephone at 866-422-0800

VRI

Personal Emergency Response Systems (PERS)

Medical alert systems can provide peace of mind if or when member have a medical emergency. Medicare members are covered for one personal emergency medical response (PERS) device per lifetime and the monthly fee at no additional cost. A PERS device provides peace of mind and 24/7 response to member's emergent and non-emergent needs. Prior authorization may be required.

VRI
800-860-4230, Option 2
Monday through Friday
5 a.m.-5 p.m. Pacific time

For more information, visit VRI.

Wellcare by Health Net Medicare Member Services Department

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

Health Net directs calls about coverage for Medicare members to the Health Net Medicare Member Services Department. If you have questions about Medicare services for these members, contact:

- 800-275-4737 (TTY: 711): Medicare Advantage (HMO) Plans (non-SNP)
- 800-431-9007; (TTY: 711): Medicare Advantage Dual Special Needs Plans (HMO D-SNP) and Medicare Advantage Chronic Special Needs Plans (HMO C-SNP)

Mail to:
Health Net Medicare Advantage for California
PO Box 10420

Van Nuys, CA 91410

Glossary

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

- AIDS
- Appeal
- Certificate of Insurance (COI)
- Clean Claim
- Clinical Trials
- Complaint
- Emergency
- Evidence of Coverage (EOC)
- Facility Site Review
- Grievance
- Hospice Services
- Inquiry
- Investigational Services
- Medical Necessity
- Medical Waste Management Materials
- Medical Information
- Not Medically Necessary
- Offshore
- Opt Out Provider
- Participating Provider
- Primary Care Physician (PCP)
- Psychiatric Emergency Medical Condition
- Residential Treatment
- Telehealth
- Schedule of Benefits or Summary of Benefits (SOB)
- Serious Illness
- Subcontractor
- Unclean Claim

Terms Glossary

This section contains general terms information for providers. Please select a term from the navigation list, or choose your line of business below.

- Medi-Cal Glossary
- Medicare Advantage Glossary
- HMO Glossary
- PPO Glossary

AIDS

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

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The definition of AIDS includes several diagnoses with and without HIV positivity. The services that are directly attributed to these specific diagnoses are paid for through special risk reinsurance. These diagnoses include:

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

Additional diagnoses associated with AIDS require a positive HIV test in order to be covered under the special risk reinsurance pool. These diagnoses include:

- CD4 T-lymphocyte count less than 200
- Recurrent pneumonia, more than one episode within one year
- Invasive cervical cancer
- Coccidiomycosis, disseminated
- HIV encephalopathy
- Histoplasmosis, disseminated

- Isosporiasis with diarrhea more than one month
- Non-Hodgkin's lymphoma
- Tuberculosis
- Recurrent salmonella septicemia
- HIV wasting syndrome

Appeal

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Member Request for Reconsideration

A verbal or written request to reconsider a previous decision or adverse determination. Requests can be from a member, the member's participating provider or the member's representative and are categorized as: pre-service, post-service, expedited, or external review.

Certificate of Insurance (COI)

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

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The Certificate of Insurance (COI) is a document issued by Health Net Life Insurance Company to employees insured under a group insurance policy, which describes the covered services, supplies and exclusions and limitations that apply to the benefits for which the employee and their insured dependents are eligible. COIs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's COI by requesting it from the Health Net Provider Services Center. COIs apply to Health Net Life, PPO, EPO and Flex Net plans.

Clean Claim

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Physician Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, physician name(s), date of service (DOS), diagnosis code(s), and billed amount among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

PPG Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, participating physician group (PPG) and physician names, date of service (DOS), diagnosis code(s), and billed amount are among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

Clinical Trials

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

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Health Net covers routine patient care costs for members participating in a qualifying clinical trial including items and services furnished in connection with participation by members in a qualifying clinical trial. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

Coverage of routine patient care costs is to be provided regardless of geographic location or if the treating provider or principal investigator of the qualifying clinical trial is a network provider. Coverage of routine patient care costs must be based on provider’s and principal investigator’s approval regarding the member’s appropriateness for the qualifying clinical trial.

Authorizations for items and services furnished in connection with participation by members in a qualifying clinical trial are expedited and completed within 72 hours.

Health Net requires the submission of the “Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial” for approval of the clinical trial. The attestation form must include the following information:

1. The member’s name and client identification number;
2. The national clinical trial number;
3. A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
4. A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

Complaint

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First Contact Resolution

Any verbal expression of dissatisfaction regarding quality-of-service (excluding quality-of-care) that can be resolved in an initial contact with Health Net's Member Services Department. This first contact resolution must be to the member or participating provider's satisfaction, such that they do not ask for additional assistance or recompense.

Emergency

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

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Health Net follows the Medicare definition of an emergency medical condition and emergency services as follows:

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Evidence of Coverage (EOC)

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

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The Evidence of Coverage (EOC) is a document containing statements of the services and benefits to which a Health Net HMO member is contractually entitled. The EOC for each HMO, HSP and POS plan contains comprehensive terms and conditions of Health Net coverage. EOCs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's EOC by requesting it from the Health Net Provider Services Center. EOCs apply to Health Net HMO, HSP and POS plans only. Language used in these documents is reflective of current laws and regulations and meets disclosure requirements applicable to health plan documents. The text included in the EOC is wholly subject to regulatory review and approval prior to use.

Facility Site Review

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

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All primary care physicians (PCPs) participating in Medi-Cal managed care are required by California statute (Title 22, CCR Section 56230) to complete an initial facility site inspection and subsequent periodic facility site inspections regardless of the status of other accreditation and/or certifications program as part of the initial credentialing process. The full scope site review includes the facility site review (FSR) and medical record review (MRR).

All PCP sites must also undergo the Physical Accessibility Review Survey (PARS). PARS is conducted for participating PCPs, high-volume specialists, ancillary providers, and hospitals. The PARS tool includes 86 criteria and highlights six specific indicators. Based on the outcome of the new PARS (Seniors and Persons with Disabilities (SPD)) evaluation, each PCP site is designated as having basic or limited access, as described below, along with the six specific accessibility indicator designations for parking, external building, interior building, restrooms, exam rooms, and medical equipment (for example, accessible weight scales and adjustable exam tables).

- Basic access - demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room, and restroom. To meet basic access requirements, all 29 critical elements must be met.
- Limited access - demonstrates facility site access for the member with a disability are missing or incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in one or more of the critical elements are encountered.

Results of the PARS assessment component of the FSR audit are made available to the Health Net Medi-Cal Member Services Department and CalViva Health Medi-Cal Member Services to assist members in selecting a PCP that can best serve the member's health care needs.

Grievance

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

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Grievance means any expression of dissatisfaction about any matter other than an adverse benefit determination (ABD), and may include, but is not limited to: the quality of care or services provided, aspects of interpersonal relationships with a provider or contractor's employee, failure to respect a member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by contractor to make an authorization decision. A complaint is the same as grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other contractor processes.

Hospice Services

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

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

For additional information refer to Criteria for Hospice Appropriateness.

Description

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

- Professional services of a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy and speech therapy
- Medical and surgical supplies and durable medical equipment (DME)
- Prescribed medications
- In-home laboratory services
- Medical social service consultations
- Inpatient hospice room, board and general nursing service

- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family or other persons caring for the member
- Family counseling related to the member's terminal condition
- Dietitian services
- Pastoral services
- Bereavement services
- Educational services

Hospice Consideration Request

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

Inquiry

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

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Member Question

Any verbal or written question for clarification, without an expression of dissatisfaction or request for reconsideration (such as a request for information or action by a member).

Investigational Services

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This definition is provided for illustrative purposes only. Consult the applicable health benefit plan contract (member's *Evidence of Coverage*) for the specific definition of *investigational or experimental.*

Investigational or experimental is used to describe a service (a medication, biological product, device, equipment, medical treatment, therapy, or procedure) that Health Net has determined is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury.

A service is considered experimental or investigational if it meets any of the following criteria:

- It is currently the subject of an active and credible evaluation (such as clinical trial or research) to determine:

- ◦ Clinical efficacy
  ◦ Therapeutic value of beneficial effects on health outcomes
  ◦ Benefits beyond any established medical based alternatives

- It does not have final clearance from applicable government regulatory bodies, such as the United States Food and Drug Administration (FDA), and unrestricted market approval for use in the treatment of a specified medical condition of the condition for which authorization of the service is requested and is the subject of an active and credible evaluation
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested

Medical Necessity

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

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Definitions of Medical Necessity and Investigational Services

Health Net's has provided clarification of terms used in its medical policies for medical necessity, investigational or experimental, and not medically necessary and not investigational. This clarification should enable participating physician groups (PPGs) to more quickly determine whether a service is considered investigational and, therefore, submit the request for a proposed service timely to Health Net for utilization management (UM) review and determination based on the terms of the provider's contract.

Commercial

Except where state or federal law or regulation requires a different definition, Health Net defines “Medically Necessary” or comparable terms in each agreement with physicians, physician groups, and physician organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition. “Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means

standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Pursuant to Insurance Code, Section 10144.52, Health Net bases any medical necessity determination or the utilization review criteria that the Plan, and any entity acting on the Plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

Medi-Cal

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

Behavioral Health Medical Necessity or Medically Necessary Definition

Except where state or federal law or regulation requires a different definition, the behavioral health team shall apply the following definition of medically necessary (Health & Safety Code: 1374.72 (3)(A)

A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the generally accepted standards of mental health and substance use disorder care.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Medi-Cal Specialty Mental Health Services (SMHS)

The federal Section 1915(b) Medi-Cal Waiver requires Medi-Cal members needing SMHS to access these services through MHPs. For individuals under 21 years of age and in accordance with California Welfare & Institutions Code (W&I Code) sections 14059.5 and 14184.402, a service is "medically necessary" or a "medical necessity" if the service meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the United States Code (USC).

The federal EPSDT mandate requires states to furnish all services it defines as appropriate and medically necessary services that could be covered under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered under the EPSDT mandate.

By contrast, for members who are 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I code section 14059.5).

Medicare Advantage

The Centers for Medicare and Medicaid Services (CMS) defines medical necessity and medically necessary services as services or supplies that: are proper and needed for the diagnosis or treatment of medical conditions, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or health care provider.

Medical Waste Management Materials

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

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The following are definitions of medical waste management materials:

Biohazard bag - A disposable red bag that is moisture-resistant and has sufficient strength to withstand ripping, tearing or bursting under normal conditions of use. A biohazard bag must be certified by the manufacturer and constructed of material of sufficient thickness strength to pass the 165 g dropped dart impact resistant test.

Biohazardous waste - Laboratory waste, including:

- medical and pathological human specimen cultures
- cultures and stocks of infectious agents
- waste from the production of bacteria, viruses or the use of spores, discarded live and attenuated vaccines, culture dishes and contaminated devices used for above
- discarded waste from specimens sent to the laboratory
- human specimens or tissues removed during surgery or autopsy, which are suspected by the attending physician or dentist of being contaminated with infectious agents

Medical waste - Biohazardous waste, sharps waste or waste generated or produced as a result of diagnosis, treatment or immunization of human beings. Medical waste may be infectious.

Sharps waste - Any device having acute rigid corners or edges or projections capable of cutting or piercing, including:

- hypodermic needles, syringes, blades, and needles
- broken glass items, pipettes and vials that are contaminated with other medical waste

Medical Information

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

“Medical information” is any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment.

“Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient’s name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

“Mental health application information” means information related to a consumer’s inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

“Mental health digital service” means a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

- Reproductive or sexual health application information – information about a consumer’s reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not

limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
- Reproductive or sexual health digital service – a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
- "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

A business entity that offers a "sexual health digital service" is now considered a "provider" under the California Medical Information Act (CMIA, 56.06)(e).

- Any business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of this part. However, this section shall not be construed to make a business specified in this subdivision a provider of health care for purposes of any law other than this part, including, but not limited to, laws that specifically incorporate by reference the definitions of this part.

Not Medically Necessary and Not Investigational

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

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Evaluation and clinical recommendations are assessed according to the scientific quality of the supporting evidence and rationale (such as national medical associations, independent panels or technology assessment organizations).

A service is considered not medically necessary and not investigational if it meets any of the following criteria:

- There are no studies of the service described in recently published peer-reviewed medical literature
- There are no active or ongoing credible evaluations being undertaken of the service, which has previously been considered not medically necessary
- There is conclusive evidence in published peer-reviewed medical literature that the service is not effective
- There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety or efficacy of the use of the service
- It is contraindicated

Offshore

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

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The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and American Virgin Islands). Examples of countries that meet the definition of offshore include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Opt Out Provider

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

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A provider who has opted out of Medicare has terminated their Part B contract with Medicare by submitting a valid affidavit to the local Medicare carrier. Affidavits are valid for two years. After the two-year period has expired, the provider may elect to return to Medicare or opt out again. Services received from a provider that has opted out of Medicare are not covered.

Participating Provider

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

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A facility, physician, physician organization, other health care provider, supplier, or other organization, which has met applicable credentialing and/or recredentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net, or indirectly through another entity, such as, another participating provider, to provide covered services.

Primary Care Physician (PCP)

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

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A doctor of medicine (MD), doctor of osteopathy (DO) or other health care professional who: (1) is duly licensed and qualified under the laws of the relevant jurisdiction to render contracted services; (2) is a participating provider and (3) meets the credentialing standards of Health Net for designation as a PCP and who provides for continuity of care and 24-hour-a-day, seven-day-a-week availability to beneficiaries.

Psychiatric Emergency Medical Condition

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

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A psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the member as being either of the following:

- An immediate danger to himself or herself or to others
- Immediately unable to provider for, or utilize, food, shelter, or clothing, due to the mental disorder

Residential Treatment

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

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Residential treatment is available, based on medical necessity with this added benefit. Medi-Cal members seeking residential treatment are referred to their respective county Specialty Mental Health division .

A residential treatment center is defined as a 24-hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. This plan requires that all contracting residential treatment centers hold appropriate licensure by their state in order to provide residential treatment services.

This plan does not cover admission to the following residential treatment facility types as they are not considered to be medical treatment:

- Foster homes or halfway houses

- Wilderness Center training
- Therapeutic boarding schools
- Custodial care, situation or environmental change

Telehealth

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

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Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver suppot for patients and includes synchronous interactions and asynchronous store and forward transfers.

- **Originating site** - The site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward transfer originates.
- **Distant site** - The site where a health care provider who provides health care services is located while providing these services via a telecommunications system.
- **Synchronous interaction** - A real-time interaction between a patient and a health care provider located at a distant site.
- **Asynchronous store and forward transfer** - The transmission/transfer of a patient's medical information from an originating site without the patient being present to the health care provider at a distant site.

Schedule of Benefits or Summary of Benefits (SOB)

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

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The Schedule of Benefits is a brief list of benefits, with applicable copayment, coinsurance and deductible information for the member's health plan. It does not list the exclusions and limitations or other important legal and contractual terms applicable to the plan; these are described in the EOC or COI.

The Schedule of Benefits is called the Summary of Benefits for certain Medicare Advantage plans, including C-SNP and D-SNP. The Summary of Benefits has the same information as the Schedule of Benefits but in a slightly different format.

The Schedule of Benefits and Summary of Benefits are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may access members' Schedule of Benefits on the provider portal. Once you log in, select *Patients* > the applicable member from the list > *Schedule of Benefits* .

Schedule of Benefits are available for all Health Net plans (except California Medi-Cal plans)

Serious Illness

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

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Serious illness is defined as a condition that may result in death, regardless of the estimated length of the patient's remaining period of life.

Subcontractor

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

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A subcontractor is any organization with which a first-tier, downstream or related entity contracts to fulfill or help fulfill requirements in its contracts.

Note: A subcontractor means an individual or entity who has a subcontract with the plan that relates directly or indirectly to the performance of the plan's obligation under the contract with the Department of Health Care Services (DHCS).

Unclean Claim

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

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An unclean claim lacks sufficient information to pay or deny, and results in an examiner requesting information from a source outside the Medicare Advantage Organizations (MAOs), such as a participating physician group (PPG) or hospital. The following are examples of claims considered to be unclean (this list is not all inclusive):

- A claim does not have the necessary fields completed to process the claim, for example, the provider identification (ID) number.
- The claim does not have a diagnosis that is immediately identifiable as an emergency, out-of-area urgently needed service, or out-of-area renal dialysis.
- The claim lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergency care.
- A claim that appears to be fraudulent or is in a foreign language or currency.

Unclean Claim Adjudication

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), MAOs and PPGs are required to pay or deny non-clean claims within 60 calendar days of receipt.

Forms and References

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

#

- 837 5010 Professional and Institutional Standards
- 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)
- Cold Sterilization Log (PDF)
- Confidential Morbidity Report (PDF)
- Criteria for Hospice Appropriateness (PDF)

D

- 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