



# Provider Manual - Combined



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# Provider Manual

The PPO (includes HSP and EPO) Operations Manual gives Health Net providers access to important plan benefits, limitations and administration processes to make sure members enrolled in the PPO, HSP and EPO plans receive covered services when needed.

The Health Net PPO, HSP and EPO plans are underwritten by Health Net of California Inc. and regulated by the California Department of Managed Health Care.

Benefits and policies listed in the PPO, HSP and EPO Operations Manual apply to all PPO, HSP and EPO plans, unless specified otherwise in the Provider Participation Agreement (PPA), Schedule of Benefits or member's Certificate of Insurance (COI). Information on tier two (PPO) and tier three (indemnity) of the Point of Service (POS) line of business is also included in the PPO Operations Manual.

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

As a Health Net participating provider, you are required to comply with applicable state laws and regulations and Health Net policies and procedures.

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

## Adverse Childhood Experiences (ACEs)

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

The following information is intended to provide a general guide to help you implement screening for adverse childhood experiences (ACEs) and better determine the likelihood a patient is at increased health risk due to a toxic stress response. Screening for ACEs helps inform patient treatment and encourage the use of trauma-informed care. For more information, visit [ACEs Aware](#).

Note: While ACE's Aware billing and payment information is specific to Medi-Cal providers, funded by Proposition 56, the ACE's Aware training materials and resources still apply to non Medi-Cal Providers. Non Medi-Cal providers can still get trained and use the workflows and tools. This article outlines how non Medi-Cal providers (that are trained and attest to training) can receive the \$29 payment.

## Prevent

Addressing trauma in primary care pediatrics can help patient remove discomfort for discussion of trauma histories. It can help connect patients and families and provide a way to prevent future trauma experiences from one generation to the next. Click here to learn more on [Preventing Childhood Toxic Stress](#).

### Trauma Informed Care

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ACEs are stressful or traumatic experiences people have by age 18, such as abuse, neglect and household dysfunction. By screening for ACEs, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response. This is a critical step in advancing to trauma-informed care.

Follow the principles of trauma-informed care. Use these key principles as a guideline:

- Establish the physical and emotional safety of patients and staff.
- Build trust between providers and patients.
- Recognize the signs and symptoms of trauma exposure on physical, psychological and behavioral health.
- Promote patient-centered, evidence-based care.
- Train leadership, providers and staff on trauma-informed care.
- Ensure provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed-upon goals for treatment.
- Provide care that is sensitive to the racial, ethnic, cultural and gender identity of patients.

## References

For more information, refer to:

- [ACEs Aware](#)
- [Health Care Toolbox](#)

## Toxic Stress

Everyone experiences stress. Stress can show up in our bodies, emotions and behavior in many different ways. Too much of the wrong kind of stress can be unhealthy and, over time, become “toxic” stress and harm physical and mental health. An adult who has experienced significant adversity in the past, especially during the critical years of childhood, may be at higher risk of experiencing health and behavioral problems during times of stress.

## References

For more information, refer to:

- [ACEs Aware](#)
- [California All](#)
- [CFAP](#)
- [Healthy Children](#)

## Positive Parenting and Resilience Building

Parents and caregivers look to providers for reliable resources, information and help to address childhood trauma. Providers can offer help by assessing parental ACE's, practicing trauma informed care to address childhood trauma and toxic stress and offer the following resources, focused on development and positive parenting skills.

- [ACEs Connection](#): News and information on ACEs and how to become more trauma-informed in practice.
- [The Center for Youth Wellness](#): Led by Nadine Burke-Harris, MD, the Center for Youth Wellness is an international leader in addressing ACEs in practice.
- [Centers for Disease Control and Prevention \(CDC\)](#): Helpful tip sheets for positive parenting at different ages.

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- **ZERO to THREE:** This organization works to ensure that babies and toddlers benefit from the early connections that are critical to their well-being and development.
- **Parenting Beyond Punishment:** No cost parenting webinars for positive discipline in everyday parenting.
- Build resilience to cope with trauma
  - **Mind Yeti:** A research-based digital library designed to help kids and their adults calm their minds, focus their attention, and connect better to the world around them.
  - **Stress Health:** Learn how the stress that humans live with can have adverse effects if there is too much for too long.
  - **American Academy of Pediatrics:** A presentation on Identifying Toxic Stress in Pediatric Practices at the 2015 American Academy of Pediatrics Event.

## Screen for ACEs

Screening for ACEs can help determine if a patient is at increased health risk due to a toxic stress response and provide trauma-informed care. Identifying and treating cases of trauma in children and adults can lower long-term health costs and support the well-being of individuals and families.

The California Department of Health Care Services (DHCS) has identified and approved specific screening tools for children and adults for the 10 categories of ACEs grouped under three sub-categories: abuse, neglect and household dysfunction.

**For children and adolescents, use [PEARLS](#).**

PEARLS is designed and licensed by the Center for Youth Wellness and are available in additional languages. There are three versions of the tool based on age:

- PEARLS for children ages 0–11, to be completed by a caregiver
- PEARLS for teenagers ages 12–19, to be completed by a caregiver
- PEARLS for teenagers ages 12–19, self-reported

**For adults, use the [ACE assessment tool](#).**

The ACE assessment tool is adapted from the work of Kaiser Permanente and the Centers for Disease Control and Prevention (CDC). Other versions of the ACEs questionnaires can be used, but to qualify, questions must contain the 10 categories mentioned above.

### Use of tools

| AGES | USE THIS TOOL | TO RECEIVE DIRECTED PAYMENT   |
|------|---------------|---|
| 0-17 | PEARLS        | Not given more than once during a 12-month period, per provider, per member |



| AGES     | USE THIS TOOL  | TO RECEIVE DIRECTED PAYMENT  |
|----------|--|--|
| 18 or 19 | ACEs or PEARLS   | Not given more than once during a 12-month period, per provider, per member  |
| 20-64    | ACEs screening portion of the PEARLS tool (Part 1) can also be used. | <p>Not given more than once during a 12-month period, per provider, per member under age 21.</p> <p>Not given more than once per lifetime, per provider, per member ages 21 and older.</p> |

The approved tools are available in two formats:

- **De-identified screening tool:** Patients have the option to choose a de-identified screening, which counts the numbers of experiences from a list without specifying which adverse experience happened.
- **Identified screening tool:** Patients can opt in for an identified screening in which respondents specify the experience(s) that happened to their child or themselves.

Providers are encouraged to use the de-identified format to reduce the fear and anxiety patients may have.

**Administering the screening**

There are several ways to administer the screening. Providers are encouraged to use the tools appropriate for their patient population and clinical workflow. Before administering, providers should consider the following:

- Identify which screening tools and format to use for adults, caregivers of children and adolescents, and adolescents.
- Determine who should administer the tool, and how.
- Determine which patients should be screened.

It is recommended that the screening be conducted at the beginning of an appointment. Providers or office staff will provide an overview of the questionnaire and encourage the patients (adolescent, adults or caregivers) to complete the form themselves in a private space to allow members to disclose their ACEs without having to explain their answers. Patients may take up to five minutes to complete the screening tool.

**References**

For more information, refer to:

- [ACEs Aware screening tools](#)
- [ACE Screening Clinical Workflows and Assessment Algorithm \(PDF\)](#)
- [ACE Screening Tools in Multiple Languages](#)

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## Treat and Heal

The ACE score determines the total reported exposure to the 10 ACE categories indicated in the adult ACE assessment tool or the top box of the pediatric PEARLS tool. ACE scores range from 0 to 10 based on the number of adversities, protective factors and the level of negative experience(s) that have impacted the patient. Providers will obtain a sum total of the number of ACEs reported on the screening tool.

For children and adults, two toxic stress risk assessment algorithms based on the score were developed to determine the level of risk and referral needs. According to the algorithm, risk and scores are determined as follows:

| RISK         | SCORE   | ACTION  |
|--------------|---|---|
| Low          | 0   | If a patient is at low risk, providers should offer education on the impact of ACEs, anticipatory guidance on ACEs, toxic stress and buffering factors.   |
| Intermediate | 1 – 3   | A patient who scores 1–3 has disclosed at least one ACE-associated condition and should be offered educational resources.   |
| High         | 1 – 3 with associated health conditions, or a score of 4 higher | The higher the score, the more likely the patient has experienced toxic stress during the first 18 years of life and has a greater chance of experiencing mental health conditions, such as depression, post-traumatic disorder, anxiety and engaging in risky behaviors. |

## Referral and Resources

As part of the clinical workflow, providers should be prepared with a treatment plan and referral process so patients who have identified behavioral, social or trauma can be connected to trained professionals and resources. Building a strong referral network and conducting warm hand-offs to partners and services are vital

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to the treatment plan. In addition, it is critical to build a follow-up plan to effectively track the patient's process to ensure they get connected to the support needed.

### **ACEs resources**

Free [ACEs resources](#) for providers on screening and clinical response.

### **Behavioral Health Services**

For Health Net:

Health Net members can obtain individual and group mental health evaluation and treatment. Providers can call [Behavioral Health Provider Services](#). It is recommended providers call the member services number on the back of the members ID card with the member to facilitate the referral and obtain member consent for treatment. Crisis support is available 24 hours a day, 7 days a week. Members can call the number on the back of their ID card to talk to someone right away.

### **Case Management**

If your patient is uncertain about next steps or would like to learn more, please refer them to the health plan's behavioral health [Case Management Department](#).

### **Health Net Community Connect**

Health Net Community Connect is powered by [Findhelp](#) formerly known as Aunt Bertha, which is the largest online search and referral platform that provides results customized for the communities you and your health care staff serve or where members live.

To use the tool, Health Net members should go to [healthnet.findhelp.com](http://healthnet.findhelp.com), enter a ZIP code and click Search.

### **myStrength**

For members with ACEs, the myStrength program can provide an additional resource. Providers should call Health Net if a member needs emergent or routine treatment services. To refer a member to the myStrength program, members can visit [myStrength.com](http://myStrength.com) to sign up online or download the myStrength app at Google Play or the Apple Store.

To join online, visit [my Strength](#), then click Sign Up and complete the myStrength sign-up process with a brief wellness assessment and personal profile.

### **Health Education Materials**

You can request materials on many key topics from Health Net's Health Education Department utilizing the form located in the Provider Library under Forms and References.

Consider ordering the below materials to support your ACEs treatment plan:

- Exercise
- Nutrition
- Parenting (stress reduction)
- Lower toxic stress
- Parenting Prevent ACEs
- Understanding ACEs
- Stress Management

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## References

For more information, refer to:

- [ACEs Screening Sample Scripts for Pediatric Clinical Teams](#)
- [ACEs Aware treatment](#)
- [ACEs Screening Clinical Workflows and Assessment Algorithm](#)
- [ACEs Aware resources](#)

## ACE Training and Self-Attestation Requirement for Billing

Effective July 1, 2022, Medi-Cal providers who have completed the two-hour online ACE training and submitted their self-attestation to DHCS can continue or begin billing for ACE screenings. Providers who missed the July 1 deadline can still complete the training, self-attest and begin billing the month of completing the attestation.

You must attest with a valid NPI number, or you will not be eligible to receive payment. Our support teams at [Provider Services](#) and [Provider Relations Department](#) will have the latest DHCS Prop 56 ACEs Provider Training Attestation List and be able to look up the customer/provider to see if DHCS has received their ACEs training attestation online form.

## How to receive payments for ACE screenings

Providers will need to complete the ACEs Aware training and must self-attest to receive payment. To get started, you must:

- Register for the “[Becoming ACEs Aware in California](#)” core training.
- Self-attest. Complete the ACEs [Provider Training Attestation](#) form.
  - Note. The ACEs Aware provider directory is optional for commercial providers.
- Submit claims for ACEs screening with dates of service on or after January 1, 2022, and proof of completion certificate. Claims eligible for payment must be submitted within one year from the date of service.
- Use CPT codes 96160 and 96161 when billing for ACE screenings.
- Claims must also include an ICD-10 code (e.g., T and Z codes around child maltreatment). In California, some ICD-10 codes have been identified as being related to ACEs screening in the state. Examples are:
  - Z59.4: Lack of adequate food or safe drinking water
  - Z63.0: Relationship problem between spouse or partners
  - Z62.819: History of abuse in childhood
  - Z63.5: Family disruption due to divorce or legal separation
  - Z63.32: Absence of family member
  - Z81.9: Family history of mental and behavioral disorder
  - Z63.72: Alcoholism and drug addiction in family
  - Z63.9: Problem related to primary support group
- Providers must document the following information and ensure the documents remain in the member’s medical record and available upon request:
  - The screening tool that was used.
  - Date the completed screen was reviewed.
  - Results of the screen.
  - Interpretation of the results.
  - What was discussed with member and/or family.
  - Include any appropriate action taken.

## Existing and future trainings on ACEs

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ACEs Aware offers a variety of trainings on ACEs and Trauma Informed Care. To access and view existing trainings or register for future trainings to support your work with ACEs, visit the [ACEs Aware site](#).

## Benefits

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

This section contains general member benefit information.

## Benefits in Alphabetical Order

Select any subject below:

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

### A

- [Acupuncture](#)
- [Alcohol and Drug Abuse](#)
- [Allergy Treatment](#)
- [Ambulance](#)
- [Autism Spectrum Disorders](#)

### B

- [Bariatric Surgery](#)
- [Behavioral Health](#)
- [Blood](#)

### C

- [Clinical Trials](#)
- [Cosmetic and Reconstructive Surgery](#)

### D

- [Dental Services](#)
- [Dialysis](#)
- [Durable Medical Equipment](#)

### E

- [Essential Health Benefits](#)

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## F

- [Family Planning](#)

## G

- [General Benefit Exclusions and Limitations](#)
- [Genetic Testing](#)

## H

- [Hearing](#)
- [Home Health Care](#)
- [Hospice Care](#)
- [Hospital and Skilled Nursing](#)

## I

- [Immunizations](#)
- [Incarcerated Members](#)
- [Injectables](#)

## J

## K

## L

## M

- [Maternity](#)
- [Medical Social Services](#)

## N

- [Nuclear Medicine](#)
- [Nurse Midwife](#)

## O

- [Obesity](#)
- [Outpatient Services](#)

## P

- [Periodic Health Evaluations](#)
- [Preventive Services](#)



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- [Prosthesis](#)

Q

R

- [Rehabilitation Therapy](#)

S

- [Support for Disabled Members](#)
- [Surgery, Surgical Supplies and Anesthesia](#)

T

- [TMJ](#)
- [Transgender Services](#)
- [Transplants](#)

U

V

- [Vision](#)

W

X

- [X-Ray and Laboratory Services](#)

Y

Z

## Acupuncture

Provider Type: Physicians | 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](#)

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# Acupuncture Services

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

The following information applies to HSP, HMO, Ambetter HMO and Ambetter PPO members.

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit for some members. Refer to the member's Evidence of Coverage (EOC) to confirm if the member is eligible for acupuncture services.

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

Refer the member to ASH Plans or the Member Services Department for more information about acupuncture services.

## Coverage Criteria

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit, subject to medical benefits exclusions, limitations and authorization protocols listed in the EOC. Subsequent visits are authorized by ASH when medically necessary as stated in the EOC.

Additional services in subsequent visits may include:

- Adjunctive therapies or modalities such as acupressure, moxibustion or breathing techniques are covered only when provided during the same course of treatment and in support of acupuncture services.

The following information applies to PPO members.

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit for some members. Refer to the member's EOC to confirm if the member is eligible for acupuncture services.

## Coverage Criteria

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit, subject to medical benefits exclusions, limitations and authorization protocols listed in the EOC. Subsequent visits are authorized when medically necessary as stated in the EOC.

Additional services in subsequent visits may include:



- Adjunctive therapies or modalities such as acupuncture, moxibustion or breathing techniques are covered only when provided during the same course of treatment and in support of acupuncture services.

#### Exclusions and Limitations

- Hypnotherapy, behavior training, sleep therapy, and weight programs.
- Services, examinations and/or treatments for asthma or addiction, such as nicotine addiction.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser BioStim<sup>®</sup>, colorpuncture, nambudripad's allergy elimination techniques (NAET) diagnosis and/or treatment, and direct moxibustion.
- Services and other treatments that are classified as experimental or investigational.
- Radiological X-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Air conditioners/purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment.
- Adjunctive therapy not associated with acupuncture.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, and herbal products, injectable supplements and injection services, or other similar products.
- Massage therapy.
- Services provided by a practitioner of acupuncture services practicing outside of the service area, except for urgent or emergency services.

## Covered Services

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

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

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

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





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# 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:

- [Overview](#)
- [Substance Abuse Facilities](#)
- [Substance Abuse Rehabilitation Services](#)
- [Minor's Consent for Services](#)

## Overview

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

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

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

## Exclusions and Limitations

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

## 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:

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- 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.

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

## Substance Abuse Rehabilitation Services

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

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

## Substance Abuse Rehabilitation Exclusions and Limitations

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

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

## Minor's Consent for Services

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

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

## Allergy Treatment

Provider Type: Physicians | Participating Physician Groups (PPG)

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

## Ambulance

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

This section contains general member benefit information on ambulance services.

Select any subject below:

- [Ambulance \(Air or Ground\)](#)
- [ModivCare](#)
- [Transfer of Members Hospitalized Out of Area](#)

## Transfer of Members Hospitalized Out of Area

Provider Type: 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.

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

## Ambulance (Air or Ground)

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

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

## Autism Spectrum Disorders

Provider Type: Physicians | Ancillary

Autism is the most common of a group of conditions collectively referred to as autism spectrum disorders (ASDs). Autism, a behavioral illness that can range on the spectrum from mild to severe, is a developmental disorder. Severe forms of autism present in the first few years of life and profoundly interfere with the individual's lifelong functioning.

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

## Screening

Autism is typically characterized by impairment in three core areas:

1. Social interactions
2. Verbal and nonverbal communication
3. Restricted activities or interests and/or unusual, repetitive behaviors

The degree of impairment in these areas varies widely from child to child.

The American Academy of Pediatrics (AAP) has added screening for autism at ages 18 and 24 months to their recommendations for preventive pediatric care. Additional follow-up in six months for borderline development of autism screening results, such as a 30-month visit, is the clinical decision of the provider.

Screenings may include:

- Assessing vision and hearing
- Directly observing the child in structured and unstructured settings
- Evaluating cognitive functioning (verbal and nonverbal)
- Assessing adaptive functioning
- Discussing with parents any concerns they have and asking specific questions regarding the child's functioning

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AAP guidelines for Autism Spectrum Disorders are available online at <https://brightfutures.aap.org>. Additional AAP autism resources are available at [www.healthychildren.org/English/health-issues/conditions/Autism/Pages/Autism-Spectrum-Disorder.aspx](http://www.healthychildren.org/English/health-issues/conditions/Autism/Pages/Autism-Spectrum-Disorder.aspx).

## Diagnostic Evaluation

Typically, the child's medical services provider or a behavioral pediatrician, a child psychiatrist, a speech and language pathologist, and other ancillary clinical specialists, as needed, provide input for a diagnosis of ASD. A thorough evaluation for ASD may include the following:

- Parents and/or caregiver interview, including siblings of the child with suspected autism
- Comprehensive medical evaluation
- Direct observation of the child
- Evaluation by a speech-language pathologist
- Formal hearing evaluation, including frequency-specific brainstem auditory evoked response
- Evaluation of the child's cognitive and adaptive functioning
- Evaluation of academic achievement for children ages six and older

There are a number of assessment tools that are used by clinicians to assist in the diagnosis of autism, including the [Health Net Diagnostic Evaluation/Assessment Form \(PDF\)](#). A list of some of the assessment tools is included in the Health Net medical policy on the [Health Net website](#).

## Medical and Behavioral Health Services

Health Net provides coverage for medical and behavioral health services, subject to limitations, copayments, coinsurance, and deductibles of the member's benefit plan. Members may access services through Health Net's participating providers or through out-of-network providers if out-of-network provider services are covered under the member's benefit plan. Some covered expenses are subject to precertification. A provider or member should request precertification, when required, before services are rendered to verify benefit coverage and ensure that the member receives full benefits. All precertifications are performed by Health Net.

Medical services for the treatment of ASD may include speech and language therapy, physical therapy, occupational therapy, and specialty management for seizure disorders and other appropriate services. Parents (or legal guardians) of the member with ASD can request a medical home with one provider or ask one provider to lead the care plan and coordinate medical services with other providers and specialists.

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

## Prescribed Treatment Plan

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The behavioral health treatment plan encompasses the professional services and treatment program. This includes ABA and other evidence-based behavioral intervention programs that develop or restore, to the maximum extent possible, the member's functioning with ASD.

A qualified autism service provider (QASP) must develop the treatment plan and review it once every six months and modify it whenever appropriate. When the treatment goals and objectives are achieved or no longer appropriate, intensive behavioral intervention services should be discontinued. The QASP must make the treatment plan available to Health Net upon request.

Health Net's participating providers are available to treat pervasive developmental disorders (PDD) or ASD. The participating provider network includes the following qualified autism service providers, who are either:

- Certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, to design, supervise or provide the treatment for PDD or ASD that is within the experience and competence of that provider's national certification.
- Licensed physicians, physical therapists, occupational therapists, psychologists, marriage and family therapists, educational psychologists, clinical social workers, professional clinical counselors, speech-language pathologists, or audiologists who design, supervise or provide treatment for PDD or ASD that is within the scope of that licensee's experience and competence.

PDD or ASD treatment is provided according to a treatment plan prescribed by a qualified autism service provider and administered by one of the following:

- A QASP
- A qualified autism service professional who is employed and supervised by the QASP
- A qualified autism service paraprofessional who is employed and supervised by the QASP

## Notification Submission

Providers must include a completed Diagnostic Evaluation/Assessment Form and a copy of the initial prescribed treatment plan when notifying Health Net of behavioral health treatment for ASD. Submit notifications to the Health Net Medical Management Department.

For ongoing care after the initial six months of service or notification period, Health Net requires the treating provider to submit an authorization request for continued services. Upon receipt of this request, Health Net conducts a medical necessity review based on the initial treatment plan, and the treating provider's updated treatment plan analysis.

## Qualified Autism Professionals

Every health care service plan subject to Section 1374.73 of the Health and Safety Code shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.

A "qualified autism service professional" is a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. These professionals can be a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or



an associate professional clinical counselor as long as these types meet the criteria for a Behavioral Health Professional as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

A “qualified autism service paraprofessional” is an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider. A qualified autism service paraprofessional can include a behavioral health paraprofessional.

Definitions of qualified autism service providers, professionals and paraprofessionals:

A “qualified autism service provider” means either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

A “qualified autism service professional” means an individual who meets all of the following criteria:

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

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

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

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- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations for a behavior management technician (paraprofessional) Behavior Management Technician (Paraprofessional) or meets the criteria set forth in the regulations adopted pursuant to subdivision (b) of Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Paraprofessional.
- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

## Educational Services

Health Net is not responsible for and does not provide coverage for educational services. An important potential source of help for educational services for children with autism is the public school system. Under Federal Public Law 94-142 (the Individuals with Disabilities Education Acts of 1990 and 1997), each school is required to provide handicapped children with free, appropriate education through age 21. The school is required to evaluate each child and, with the parents, develop an individual education plan (IEP). The IEP determines the educational setting that is most appropriate for the child, establishing goals for each child that are academic and behavioral/social. The local public school system may provide for or refer the child for educational interventions, such as Lovaas therapy, intensive behavioral intervention (BI), discrete trials training, early intensive behavioral intervention (EIBI), intensive intervention programs, Picture Exchange Communication Systems (PECS), facilitated communication, Treatment and Education of Autistic and Related Communication of Handicapped Children (TEACCH), or floor time.

The local school system is responsible for education services once the child reaches age three. California's Early Start Program (for children under age three) or the local regional center (for children ages three and up) provides other services, such as in-home services.

Health Net is not responsible for and does not provide coverage for educational services (except for medically necessary ABA services for Health Net PPO members diagnosed with ASDs when coverage is mandated by the state).

## Case Management/Comanagement

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

## Coordination of Care

Health Net expects all providers involved in the treatment of a member with ASD to coordinate the care and treatment they are providing through appropriate communication. Communication helps prevent duplication of tests and contraindicated medications and treatment, and allows providers the opportunity to modify the member's treatment plan based on more thorough information.

Coordination with the school system, Early Start Program, and regional centers regarding educational services helps ensure the ASD member receives the full range of service options.

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## Nurse Advice Line

The [Nurse Advice Line](#) offers highly trained registered nurses for condition-specific support, 24 hours a day, seven days a week to members. Refer to the Nurse Advice Line to discuss health concerns of ASD for Health Net members.

## Resources

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

- [AAP recommendations for preventive care](#)
- [Early Start Program](#)
- [Health Net website](#)
- [Individuals with Disabilities Education Act](#)
- [Other AAP resources](#)
- [Regional Centers contact information](#)

## Bariatric Surgery

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

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

Direct network physicians and non-delegated PPGs may submit prior authorization requests for bariatric surgery to [Health Net Medical Management Department](#).

## Compliance for Bariatric Hospitals and Surgeons

Health Net's standardized review process monitors and evaluates bariatric surgery participating providers' quality and outcomes to ensure access to high-quality bariatric surgical care for Health Net members. Health Net bariatric performance centers must be accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) or currently in the accreditation application process. Hospitals and surgeons must continuously be in good standing through MBSAQIP and other industry-accepted oversight organizations.

Health Net's bariatric surgery participating providers are evaluated at least every calendar year to ensure each hospital and surgeon meets Health Net criteria. This evaluation is based on data reported each calendar year by the participating provider using Health Net's data submission process. Health Net may conduct off-cycle reviews upon discovery of substandard clinical care practices, as evidenced by changes in the participating provider's MBSAQIP designation level.

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## Evaluation Criteria

Health Net's bariatric surgery participating providers are evaluated annually based on the following criteria.

Hospitals:

- Volume must meet a minimum of 125 bariatric surgery procedures every two calendar years
- 30-day mortality must be equal to or less than one percent
- One-year mortality must be equal to or less than one percent

Surgeons:

- Volume must meet a minimum of 50 bariatric surgery procedures every two calendar years
- 30-day mortality must be equal to or less than one percent
- One-year mortality must be equal to or less than one percent

## Data Monitoring

Health Net identifies regularly monitored measures based on the above criteria or when a new industry standard is set. Health Net may request an explanation from the hospital or surgeon when results fall below standards. Additionally, each year, Health Net collects and reviews data to adhere to the following specifications:

- The percentage of readmissions must be equal to or less than five percent
- Average length of stay (ALOS) must be equal to or less than the current Milliman Benchmarks for surgical procedures
- The percentage of complications must be equal to or less than three percent

## Letter of Deficiency Process

If a bariatric surgeon does not comply with evaluation criteria, Health Net sends a letter of deficiency and indicates if a response is required within 21 days. If the provider does not respond by the deadline and a response is required, Health Net sends a certified letter with a two-week extension. If the provider still does not respond after the second deadline has expired, Health Net sends a third and final notice to the participating provider regarding the deficiency. This notice informs the participating provider of Health Net's decision including potential termination of the bariatric surgery program due to non-response.

## Corrective Action Plan Submission and Implementation

If a bariatric surgery participating provider does not comply with all of the evaluation criteria or results are deficient for three consecutive periods, a corrective action process may be initiated and a corrective action plan (CAP) requested. Health Net may request that the provider submit explanations prior to the request for a formal CAP. Additionally, if a program does not meet the criteria standards required for bariatric surgery performance

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centers or is under investigation by MBSAQIP or any other industry-accepted oversight organizations, Health Net requests that the bariatric surgery program share the oversight organization's findings and recommendations.

When requested, based on non-compliance with bariatric surgery criteria, the bariatric surgery participating hospital or surgeon must submit the CAP within 21 calendar days. Health Net reviews it to ensure it is appropriate and complete. If Health Net does not approve the CAP, a second notice is sent to the bariatric surgery participating provider allowing an additional 15 calendar days to revise the CAP and resubmit it to Health Net.

Health Net sends a third and final notice to the bariatric surgery participating provider upon continued non-responsiveness requests for a CAP or insufficient progress towards correcting the deficiencies. This notice informs the participating provider of Health Net's decision, including potential termination of the bariatric surgery program. Bariatric surgery participating providers may avoid these actions if both of the following occur:

- The provider submits an acceptable CAP to Health Net within 15 calendar days of receipt of the final notice
- The provider completes and demonstrates substantial progress toward completing the correction within 30 calendar days

The bariatric surgery provider must submit updates six months and one year after the original CAP submission date, or until completion of the CAP. If volume or outcome criteria are not met for two sequential data collection periods, Health Net may suspend new patient referrals for that participating provider. If criteria are not met for three sequential data collection periods, Health Net may take a remedial action, up to and including termination of the participating provider's contract.

## Onsite Visits

At any time, either Health Net or a bariatric surgery provider may request, with reasonable advance notice, a meeting at the provider's office to discuss bariatric surgery program issues or concerns. Both parties must agree to attend.

## Adding Bariatric Surgeons or Performance Centers

Existing Health Net bariatric surgeons who are interested in adding bariatric surgeons to their practice must have the surgeons undergo the request for information (RFI) process. Hospitals interested in becoming a Health Net performance center must be accredited by MBSAQIP and undergo an RFI process. Providers may request and RFI via email at [cqi\\_dsm@healthnet.com](mailto:cqi_dsm@healthnet.com)

## 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:

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- [Overview](#)
- [Behavioral Health Customer Service](#)
- [Coordination of Care](#)
- [Day Care Treatment](#)
- [Dual Diagnosis](#)
- [Employee Assistance Program](#)
- [Exclusions](#)
- [General Guidelines for Referrals](#)
- [Obtaining Behavioral Health and Substance Abuse Care](#)
- [Out-of-Area Cases Involving an Acute Medical Diagnosis](#)

## Overview

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

Health Net manages inpatient and outpatient treatment for behavioral health and substance abuse care. Health Net has an extensive network of qualified practitioners and facilities. The network includes psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors, as well as psychiatric and substance abuse facilities and programs. All practitioners and facilities meet strict credentialing requirements. Members with behavioral health benefits have access to its network of behavioral health practitioners and providers. Health Net's behavioral health program provides inpatient care, including detoxification; outpatient care; day treatment; [residential treatment](#); and structured outpatient treatment programs.

In addition, Health Net provides members with a single source for all the necessary components of a comprehensive behavioral health and substance abuse programs, including:

- Claims administration
- Customer service
- Provider services and contracting
- 24-hour phone access for clinical screening information and referral
- Care management and quality improvement

## Copayment

A copayment may be collected from the member at the time services are rendered for some covered behavioral health and substance abuse services. The [Schedule of Benefits](#) located in the member's [Evidence of Coverage](#) (EOC) provides copayment information. Any required copayment should be collected by the Health Net provider or facility rendering the services.

## Criteria for Behavioral Health and Substance Abuse Treatment

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All eligible members who call Health Net for a referral are screened by a customer service representative. If the member is in distress or appears to require treatment at a higher level than standard outpatient, they are transferred to a licensed clinical care manager for more complete assessment and referral to treatment. If the member is requesting a routine outpatient referral, the customer service representative provides them with names and contact information for several providers in their area. Outpatient office-based psychotherapy and medication evaluation/management does not require prior authorization. However, requests for facility-based care (with the exception of life-threatening emergencies), and psychological/neuropsychological testing, must be evaluated for medical necessity and prior authorized by Health Net. Members who present with conditions not related to a behavioral health disorder may be referred to community resources or the primary medical provider as appropriate.

Participating providers may also refer members for routine behavioral health services by advising the member to contact the Member Services number listed on the back of their ID card.

## Coordination of Care

Provider Type: Physicians | Participating Physician Groups (PPG)

Behavioral health providers and the member's primary care physician (PCP) need to be able to contact each other in the event that the behavioral health provider discovers a medical condition or the PCP identifies a psychiatric or substance abuse problem during a medical examination.

After the behavioral health provider conducts an initial assessment, the behavioral health provider or clinical care manager should coordinate care with the member's PCP if a medical condition is discovered. Behavioral health providers can contact [Behavioral Health Provider Services](#) for help in coordinating care for members who require specialized assistance in managing co-occurring medical and behavioral health conditions.

Although the Health Insurance Portability and Accountability Act (HIPAA) allows for communication between clinical practitioners for purposes of treatment coordination without member authorization, behavioral health practitioners are encouraged to discuss this with each member. In order to maintain member confidentiality, a written release form signed by the member is necessary for release of psychotherapy notes (session notes in the medical record consisting of the content of conversation during a private, group, joint, or family counseling session).

Coordination of care between the member's medical and behavioral providers is encouraged in the following situations:

- When a behavioral health practitioner begins prescribing psychotropic medications or makes significant changes to the regimen.
- A new member reports a concurrent medical condition, a substance abuse disorder and/or a major mental illness (for example, a condition other than an adjustment disorder) or when there is a change in condition for an established member.
- A behavioral health practitioner is considering treatment that requires a medical evaluation (for example, electroconvulsive therapy).
- A PCP or other medical provider refers a member to a behavioral health practitioner.

If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the PCP may contact [Behavioral Health Provider Services](#). Participating providers may also refer members for routine behavioral health services by advising members to contact the Member Services number listed on the back of their ID card.



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## Day Care Treatment

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

When a member requires day care mental health treatment for four to eight hours per day in a mental health facility, any partial day treatment applies toward the outpatient mental health coverage. Verify that the member has outpatient mental health coverage by reviewing the [Schedule of Benefits](#).

## Dual Diagnosis

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

For cases requiring both behavioral health and medical treatment services, the behavioral health clinician and medical provider determine a mutually acceptable treatment plan. This makes both treatments more effective. Conversations between the behavioral health provider and the member's health care providers should occur as necessary to ensure the treatment plans are managed together and the member's coverage is correctly applied between the two delivery systems.

## Employee Assistance Program

Provider Type: Physicians | Participating Physician Groups (PPG)

The primary focus of the Employee Assistance Program (EAP) is to resolve short-term issues. If a member needs ongoing assistance with behavioral health needs, the EAP clinician can conduct an assessment and furnish referrals to appropriate treatment resources, such as those covered by the employee's health insurance plan, or to community resources.

Many members accessing EAP services are not looking for or are not in need of psychotherapy. Members can access services for a range of reasons. The most common presenting problem is marital and family concerns. However, members also use EAP for problems in the workplace; stress, anxiety and sadness; alcohol and drug dependency; grief and loss; and other emotional health concerns.

In addition, EAP offers eligible members and their family members an array of non-clinical services. EAP experts provide telephonic guidance and referrals to help with financial and legal matters, identity theft recovery, childcare, elder care, and pre-retirement planning.

EAP providers can refer members to the Health Net behavioral health provider network and, when needed, coordinate care with the member's primary care physician (PCP) or participating physician group (PPG). Clinical care managers are available to work with EAP providers on referrals to behavioral health providers and programs.



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

The following are general exclusions that are not covered under the behavioral health program:

- Non-treatable disorders: Mental disorders or substance abuse conditions that Health Net determines are not likely to improve with generally accepted methods of treatment or conditions excluded from coverage.
- State hospital treatment: Treatment or confinement in a state hospital are limited to treatment or confinement as the result of an emergency or urgent care.
- Non-standard therapies: Services that do not meet national standards for professional mental health practice, such as Erhard/The Forum, primal therapy, bioenergetics therapy, crystal healing therapy and therapies deemed experimental or investigational by medical policies.
- Psychological testing: Psychological testing for learning disabilities, academic difficulties, and educational achievement testing are not covered. Testing for attention deficit hyperactivity disorder (ADHD) as a single diagnosis, or not part of diagnostic clarification is also not a covered benefit. Psychological testing must be conducted by a licensed psychologist or psychiatrist, and must be medically necessary to diagnose or treat a mental health disorder.
- Prescription medications: Outpatient prescription medications or over-the-counter medications.
- Private-duty nursing: Private-duty nursing services in the home or in a hospital
- Insurance: Services for obtaining or maintaining insurance.
- Aversion therapy: Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus.
- Treatment for co-dependency: Treatment for co-dependency services, unless they are provided for a treatable mental disorder.
- Wilderness programs or therapeutic boarding schools not licensed as residential treatment centers.
- Non-participating providers: Services provided by mental health professionals or facilities not contracting with Health Net, except in those cases where Health Net refers a member to a non-participating provider or authorizes emergency or urgently needed care.
- Treatment by a relative: Treatment or consultation provided by the member's parents, siblings, children, current or former spouse, or any adults who live in the member's household.
- Education and employment services: Services related to educational, vocational and professional purposes, including:
  - Treatment of learning disabilities, borderline intellectual functioning and mental retardation.
  - Vocational rehabilitative education.
  - Investigations required for employment.
  - Education for maintaining employment or for professional certification.
  - Education for personal or professional growth, development or training, including vocational counseling.
  - Academic education during [residential treatment](#).
- Testing, screening or treatment for learning disabilities.
- Specialized treatment program for smoking cessation, weight reduction, obesity, stammering, stuttering, or sexual addiction.

The following types of treatment, except when provided in connection with covered treatment for a behavioral disorder or substance abuse condition:

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- Treatment ordered by a court or treatment related to judicial/legal proceedings, including child custody, driving under the influence (DUI), driving while intoxicated (DWI), divorce, or child/elder/spousal abuse or neglect.
- Treatment of chronic pain.
- Treatment for co-dependency.
- Treatment for psychological stress.
- Relational problems, such as marital dysfunction, parent/child dysfunction, sibling dysfunction, spousal abuse, and work-related conflicts.
- Problems of daily living, such as stress, work, unemployment, uncomplicated bereavement, homelessness, poverty, phase of life, acculturation/discrimination, victim of crime/terrorism, incarceration, religious/spirituality problems, unwanted or conflicted pregnancy, lifestyle conflicts, and malingering.

For additional list of exclusions, providers must refer to the member Evidence of Coverage (EOC).

## General Guidelines for Referrals

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

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

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

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## Behavioral Health Customer Service

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

Customer service is available 24 hours a day, seven days a week through the phone number listed on the back of the member's identification (ID) card. The following services are available to members:

- Claims inquiry
- Clinical referral
- Eligibility inquiry
- Explanation of behavioral health benefits, including exclusions and limitations
- Referral for crisis triage/evaluation and referral

## Obtaining Behavioral Health and Substance Abuse Care

Provider Type: Physicians | Hospitals | Ancillary

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

PPO members may seek care at any time from any PPO participating behavioral health or substance abuse specialist. Physicians may also decide that it is necessary for a member to receive treatment from a behavioral health or substance abuse specialist and should refer the member to a participating specialist when possible. Prior authorization is not required for outpatient professional services. To determine whether a behavioral health or substance abuse specialist is a PPO participating provider, physicians can call the [Health Net Provider Services Department](#).

## Out-of-Area Cases Involving an Acute Medical Diagnosis

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

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

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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.

## Clinical Trials

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

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

Select any subject below:

- [Coverage Explanation](#)

## Coverage Explanation

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

Health plans or delegated participating physician groups (PPGs) must cover all medically necessary routine patient care costs related to a clinical trial for a member who has been accepted for participation in a nationally recognized phase I, II, III, or IV clinical trial. The member must also be diagnosed with cancer or other life-threatening disease or condition, or their physician otherwise recommended participation in the clinical trial.

The Health Net prior authorization letter for an approved clinical trial identifies items and services that are considered part of the clinical trial to the extent they are known at the time of initial review. These items and services are covered by the study entity. For HMO plans, the initial and any follow-up authorizations also specify which foreseeable items are routine services and costs that the member must obtain in-network, unless the member's PPG authorizes the services to be rendered out-of-network.

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

Members are eligible for participation in clinical trials if they meet the trial protocol. These trials are for treatment with a medication that is exempt from federal regulation in relation to a new medication application, or is approved or funded by one of the following:

- Agency for Healthcare Research and Quality (AHRQ).
- Centers for Disease Control and Prevention (CDC).
- Centers for Medicare & Medicaid Services (CMS).
- National Institutes of Health (NIH).
- Food and Drug Administration (FDA) as an investigational new medication application.
- A cooperative group or center for any of the entities described in clauses (i) to (iv) above, inclusive, the United States Department of Defense (DOD), the Department of Veterans Affairs (VA) or the Department of Energy..
- Qualified non-governmental research entity identified in the guidelines issued by NIH and meets criteria established by the NIH for grant eligibility.

Providers must provide the treatment or conduct the study within their scope of practice, experience and training. They must also agree to accept reimbursement as payment in full from Health Net at Health Net-established rates that is not more than the level of reimbursement for other similar services provided by participating providers.

Refer to [definition of clinical trials](#) for more information.

## Exclusions

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

- Medications or devices not approved by the Food and Drug Administration (FDA)
- Travel, housing, companion expenses, and other non-clinical expenses
- Items or services used solely for data collection and analysis. Health Net does not cover imaging or lab tests beyond those reasonably necessary for routine care
- Health care services customarily provided free of charge by the research sponsors of the clinical trial
- Any medication, item, device, or service that is specifically excluded from coverage under the medical plan
- Any investigation medication or device provided in a phase I clinical trial
- Any costs for managing the research of the clinical trial
- Treatment or services outside California are not covered if the clinical trial is offered in California

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- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Health plans are not required to provide benefits for routine patient care services provided outside of the plan's provider network unless out-of-network benefits are otherwise provided by the plan.

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

## Qualified Individual

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

- Diagnosis of cancer or other life-threatening disease or condition, or otherwise eligible to participate in an approved clinical trial according to the trial protocol
- Member or member's provider supplies medical and scientific documentation establishing that the member's participation in such a trial would be appropriate based upon them meeting the guidelines and eligibility criteria

## Routine Patient Care Cost

By state and federal law, payment for routine patient care costs associated with participation in the approved clinical trial must be provided under the member's medical plan. This means that if the medical plan covers a medication, item, device, or service for care not related to participation in the approved clinical trial, then the charges for the same care related to participation in the approved clinical trial must be covered. Some examples of routine patient care costs that might be covered include:

- Physician consultations
- Medications
- Radiological or diagnostic testing services
- Inpatient care
- Services required for the provision of the medication, device or medical treatment being tested in the clinical trial
- Clinically appropriate monitoring of the effects of the medication, device or treatment being tested
- Any reasonable and necessary care for the prevention of complications

## Utilization Management Process

PPGs or directly contracting physicians should use the following process when requesting that Health Net provide prior authorization for a Health Net member to participate in an approved clinical trial:

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

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

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

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

## Cosmetic and Reconstructive Surgery

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

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

Select any subject below:

- [Breast Cancer Reconstructive Surgery](#)
- [Cleft Palate Diagnoses](#)

## Breast Cancer Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Treatment for breast cancer includes coverage of prosthetic devices or reconstructive surgery to restore and achieve symmetry for the member incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery is subject to copayment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits.

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

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

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## Cleft Palate Diagnoses

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

Health Net covers medically necessary dental or orthodontic services that are an integral part of cleft palate reconstruction. Cleft palate may also include, cleft lip or other craniofacial anomalies associated with cleft palate.

To the extent that Medi-Cal members who require medically necessary dental or orthodontic services are determined eligible for the California Children's Services (CCS) program, these services are provided by CCS.

Prior authorization for cleft palate reconstruction, including dental and orthodontic services, is required for all HMO, EPO, Point of Service (POS), and PPO products.

## 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](#)
- [General Anesthesia Coverage and Exclusions](#)

## Overview

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

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

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

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

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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.

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# General Anesthesia Coverage and Exclusions

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

## General Anesthesia Coverage

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

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

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

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

## General Anesthesia Exclusions

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

## Dialysis

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

This section contains general member benefit information on dialysis.

Select any subject below:

- [Overview](#)



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

Dialysis services are covered on all plans. Refer to the specific plan chart in the [Schedule of Benefits](#).

## Out-of-Area Dialysis

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

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

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

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

## Out-of-Country Dialysis

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

## 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:

- [Coverage](#)
- [Exclusions and Limitations](#)
- [Orthotics](#)

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## Coverage

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

Medically necessary durable medical equipment (DME) is covered under all health plans. Refer to the [Schedule of Benefits](#) and the member's [Certificate of Insurance](#) or [Evidence of Coverage](#) (EOC) as applicable to determine exclusions and limitations, as applicable. Apria Healthcare is the preferred provider for DME for PPO and EPO plans.

DME benefits include but are not limited to:

- Wheelchairs
- Walkers
- Crutches
- Canes
- 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
- Intermittent positive-pressure breathing machines
- Oxygen
- 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

Members who do not have diabetic supply coverage through their pharmacy benefit, have a benefit for diabetic supplies under their DME coverage. They should obtain test strips and supplies from a contracted DME vendor. For more information regarding a member's benefits, refer to the introduction pages in the Schedule of Benefits. Refer to the Schedule of Benefits to determine coverage.

- Insulin pumps are covered through DME 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
- Infant apnea monitor - This item is covered for use in the hospital or at home
- Phototherapy (bilirubin lights)
- Medically necessary lactation DME (electric breast pump) - Health Net's preferred breast pump provider is [Pumping Essentials](#)

Prescriptions for lactation-related DME must be written by a licensed physician, physician's assistant, nurse practitioner, certified nurse midwife, or certified lactation consultant with a license to practice medicine or nursing. Health Net requires a prescription from the member's physician for a breast pump from Pumping Essentials; however, no prior authorization is needed.

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Lactation-related DME, including electric pumps (if the member prefers, battery operated pumps can be substituted) and pump kits (one per member), do not require prior authorization from the PPG for the first two months of use. Longer use requires documentation of continued clinical need and current successful use.

Custom footwear and custom shoe inserts are not a standard covered benefit, and are only covered on specific plans. However, custom footwear and custom shoe inserts are covered for members with diabetes, to prevent or treat diabetes-related complications. For members with diabetes the extra foot orthotic benefit coverage includes one pair of extra depth or custom molded shoes (including non-customized removable inserts provided with the shoes) and three pairs of inserts each calendar year.

## Exclusions and Limitations

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

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

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

## Orthotics

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



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

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

## 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.](#)
- [ATG Rehab Specialists, Inc.](#)

For insulin pumps and supplies, contact [Animas Diabetes Care, LLC](#), [MiniMed, Inc.](#), [Roche](#), 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.

## Essential Health Benefits

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

Health Net provides coverage consistent with the Essential Health Benefits (EHBs) coverage requirement in accordance with the Affordable Care Act (ACA). EHBs include items and services that fall into at least the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including dental and vision care

Actual EHB services vary by state, as each state may define EHB in accordance with its state benchmark plan. Plans subject to the EHB requirement must provide benefits that are equal to or greater than the state benchmark plan's benefits. Annual dollar limits on EHB are prohibited. Additional information regarding state

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benchmark plans is available on the Center for Consumer Information and Insurance Oversight (CCIIO) website at [www.cms.gov/cciiio/index.html](http://www.cms.gov/cciiio/index.html).

## Family Planning

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

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

Select any subject below:

- [Overview](#)
- [Infertility Treatment](#)

## Overview

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

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

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

## Contraceptive Devices

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

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

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

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

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

## Intrauterine Devices

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

## Exclusions and Limitations

The following are exclusions and limitations on family planning coverage:

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

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

## Infertility Treatment

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

Some plans cover specific infertility services as referenced in the member's [Evidence of Coverage](#) (EOC) or [Certificate of Insurance](#) (COI). Before beginning infertility treatment, the member's treating practitioner must establish a treatment plan. Refer to the [Schedule of Benefits](#) for specific information concerning plans that cover gamete intrafallopian transfer (GIFT). If these benefits have not been purchased, Health Net must notify the member in writing of coverage limitations.

If a member has not conceived in a particular treatment plan, the member's treating practitioner should re-evaluate the plan and change the therapy. If the member is still unsuccessful, advanced treatment under the guidance of a reproduction endocrinologist or fertility specialist should be considered. The treatments below are covered when the following specified conditions are met:

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- Artificial insemination (AI), intrauterine insemination (IUI), GIFT and sperm washing - Covered when used in treatment of infertility (ovulation sticks are not covered)
- IVF/ZIFT - Only certain plans cover IVF or ZIFT. Refer to the Schedule of Benefits for specific plan information

Refer to the Schedule of Benefits (SOB) for availability of infertility treatment; this is also referenced within the member's Evidence of Coverage. The treatment used for each infertile member may be different and should be individualized based on medical indications. Most Health Net plans subject infertility services to a 50 percent copayment. The copayment amount is based on the percent copayment multiplied by the average wholesale price or the actual cost of the injected substance, whichever is less.

The required copayments for infertility procedures may or may not apply to the out-of-pocket maximum (OOPM). Refer to the Introduction pages of the Schedule of Benefits for a list of exception groups.

GIFT is covered when:

- Plan covers standard infertility treatments/benefits
- GIFT procedure is medically indicated
- GIFT is performed by a reproductive endocrinologist or fertility specialist

## Infertility Treatment (Ancillary and PPGs only)

Diagnosis of infertility may be appropriate for members who have not yet gone through menopause and have any of the following:

- The member has had coitus relations on a recurring basis for one year or more without use of contraception or other birth control methods which has not resulted in a pregnancy, or when a pregnancy did occur, a live birth was not achieved.
- The member does not have coitus with a male partner.
- A licensed physician's determination of infertility, based on the member's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Infertility services is an optional benefit in employer group plans. When Health Net plans cover infertility treatment, coverage includes procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including but not limited to diagnosis, diagnostic tests, medication, surgery, artificial insemination (AI), intrauterine insemination (IUI) and gamete intrafallopian transfer (GIFT). Some custom employer group plans include coverage of advanced reproductive technologies (ART), in vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT). Refer to the [Schedule of Benefits](#) and [Evidence of Coverage](#) (EOC) or [Certificate of Insurance](#) (COI) for coverage information and applicable copayments. Before beginning infertility treatment, the member's treating provider must establish a treatment plan.

If a member has not conceived in a particular treatment plan, the member's treating provider should re-evaluate the plan and change the therapy. If the member is still unsuccessful, advanced treatment under the guidance of a reproductive endocrinologist or fertility specialist should be considered. The number of cycles, or a dollar amount limit of a particular treatment plan and assistive reproductive technologies, may be limited under the member's plan. Consult the member's evidence of coverage. The standard and advanced treatments below are covered when the specified conditions are met.

### Standard Infertility Treatments

Intrauterine insemination may be performed using either the partner's sperm or donor sperm.

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Donation, storage and banking of member or donor sperm are not covered.

GIFT is covered when:

- Plan covers standard infertility treatments/benefits
- GIFT procedure is medically indicated
- GIFT is performed by a reproductive endocrinologist or fertility specialist licensed in the field

The required copayment for infertility procedures may or may not apply to the out-of-pocket maximum (OOPM), Refer to the introduction of the [Schedule of Benefits](#) for a list of exception groups.

## Advanced Infertility Treatments

Assisted reproductive technologies (ART), IVF and ZIFT are advanced infertility treatment procedures.

For plans that cover ART, but limit the services to dollar limits, or a specified number of cycles per lifetime, ART is defined as:

- All office visits, procedures, blood work, and ultrasounds performed in preparation for oocyte retrieval
- Retrieval of the oocyte itself
- Culture and fertilization of the oocyte
- Embryo transfer

A cycle is counted toward the lifetime maximum once the member has had her oocytes retrieved, whether or not there is fertilization of the oocyte.

Before a member is eligible for ART coverage, alternate treatments must be attempted without success. The treatment used for each infertile member may be different and should be individualized based on medical indications. Most Health Net plans subject infertility services to a 50 percent copayment. The copayment amount is based on the percent copayment multiplied by the average wholesale price or the actual cost of the injected substance, whichever is less.

The required copayments for infertility procedures may or may not apply to the out-of-pocket maximum (OOPM). Refer to the Introduction of the Schedule of Benefits for a list of exception groups.

## Exclusions and Limitations

General infertility services that are not covered include:

- Ovulation kits
- Partner's diagnosis and treatment if the partner is not covered by Health Net
- Benefits for reversal of voluntary sterilization unless otherwise stated by the member's EOC or COI
- Infertility treatment needed as a result of prior voluntary sterilization
- Donation, storage and banking of member or donor sperm or ova for future use
- Unless otherwise stated in the EOC or COI, the testing, storage and transport fees or any other charges incurred
- Sperm washing when used in preparation for a non-covered procedure
- Surrogacy or gestational carriers unless the surrogate is a Health Net member who has been diagnosed with infertility. When compensation is obtained for the surrogacy, Health Net or the participating provider may have a lien on such compensation to recover its medical expense
- Gender selection
- Donor eggs for women with genetic oocyte defects

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- Donor sperm for men with genetic sperm defects
- Genetic engineering
- Co-culture of embryos

## General Benefit Exclusions and Limitations

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

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

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

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



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

## General Benefit Exclusions and Limitations (Physicians Only)

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

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  - Hair transplant, hair analysis, hairpieces, wigs, and cranial or hair prostheses
  - Chemical face peels and abrasive procedures of the skin
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- In contrast to the exclusion for cosmetic surgery, reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
  - To improve function
  - To create a normal appearance, to the extent possible
  - Coverage for reconstructive surgery also includes:
    - Breast surgery and all stages of reconstruction for the breast on which a medically necessary mastectomy was performed and to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast
    - Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate, including cleft lip or other craniofacial anomalies associated with cleft palate
  - Custodial or domiciliary care - Services and supplies that are provided primarily to assist with the activities of daily living are not covered, regardless of the type of facility. Care provided by a hospice for a terminally ill member or for a condition that requires continuous skilled nursing services is not considered custodial or domiciliary
- Dental services - Care or treatment of teeth and gingival tissues, extraction of teeth; treatment of dental abscess or granuloma, other than tumors, dental examinations, spot grinding, crowns, bridge work, onlays, inlays, dental implants, braces, and any orthodontic appliances are not covered unless specifically provided in the member's EOC
- Disorders of the jaw -Treatment and services for temporomandibular joint (TMJ) disorder are covered when determined to be medically necessary, except:
  - Crowns
  - Inlays
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  - Dental implants
  - Bridgework (to treat dental conditions related to TMJ disorder)
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- Hearing aids - Any device inserted in or affixed to the outer ear to improve hearing is not covered, unless specifically provided in the member's EOC
- Ineligible status - Services or supplies provided before the effective date of coverage or after the date coverage has ended are not covered, except as specified in the extension of benefits portion of the member's EOC
- No-charge items - Services or supplies the member is not required to pay for or for which no charge is made are not covered
- Non-covered items - Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the [Schedule of Benefits](#) to determine exclusions, limitations and applicable copayments. Non-covered items are:
  - Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, treadmills, and free weights
  - Supplies to achieve cleanliness even when related to other medical services
  - Surgical dressings, except primary dressings that are applied directly to lesions either of the skin or surgical incision, which are covered as a standard medical benefit. Over-the-counter dressings and supplies are not covered
  - Jacuzzis and whirlpools
  - Stockings, such as elastic stockings, job stocking and support hose, garter belts and similar devices, as not within the definition of brace
  - Orthotics that are not custom-made to fit the member's body. Orthotics are orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belt
  - Corrective footwear (specialized shoes, arch supports and inserts) except for the treatment of diabetes-related medical conditions, or as specifically provided in the member's EOC
- Non-eligible institutions - Services or supplies provided by any institution other than a licensed and approved hospital or Medicare-approved skilled nursing facility (SNF) or other properly licensed facility specified as covered in the member's EOC are not covered. Any institution that is primarily a place for the aged, a nursing home, or any similar institution, regardless of how designated, is not an eligible institution
- Non-prescription (over-the-counter) medications, equipment and supplies - Any medications, equipment and supplies that can be purchased without a prescription order is not covered, even if a physician writes a prescription for it (except insulin and diabetic supplies or as specifically provided in the EOC)
- Personal or comfort items - Personal or comfort items, such as a telephone or television in the room at a hospital or SNF, are not covered



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

## Genetic Testing

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

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

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

## Genetic Testing Coverage

Medically necessary genetic testing is covered for the following conditions:

- Tay-Sachs disease (TSD)

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

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

## Indications for Covering Genetic Testing

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

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

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





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

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

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

## Hearing Aid

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

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

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

## Exclusions and Limitations

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

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

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

## Home Health Care

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

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

## Home Health Care Services

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

The following are additional components of home health care:

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

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

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

## Service Providers

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

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

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

## Homebound Determination

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

- The member must either, because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of

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another person in order to leave their place of residence; or have a condition that makes leaving their home medically contraindicated.

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

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

If the member does leave home, they are considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.

Absences attributable to the need to receive health care treatment include, but are not limited to:

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

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

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

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

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

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

## Exclusions and Limitations

The following are not covered:

- food, housing, homemaker services, and home-delivered meals.
- supportive environmental equipment, such as handrails, ramps, and similar appliances and devices (not an exclusion for Cal MediConnect members).
- services not deemed to be medically necessary by the PPG, PCP or Health Net.
- exercise equipment, gravitonic devices, treadmills, room air purifiers, air conditioners, and similar devices.

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- any other equipment that is not considered by the Centers for Medicare & Medicaid Services (CMS) to be durable medical equipment (DME).

## Authorization Guidelines

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

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

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

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

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

## Physician Certification

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

## Physician Recertification

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

## Ongoing Care

**Participating providers** initiate home health care services as follows:

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

For more information, select any subject below:

- [Skilled Nursing Services](#)

## Skilled Nursing Services

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

The following are skilled services other than skilled nursing services:

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

## Skilled Nursing Observation and Evaluation

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

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

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

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

## Hospice Care

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

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

Select any subject below:

- [Hospice Services](#)
- [Claims Submission](#)
- [Hospice Agency](#)
- [Interdisciplinary Team](#)
- [Prior to Election of Hospice Services](#)

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## Hospice Services

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

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

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

### Description

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

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

### Hospice Consideration Request

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

### Certification of Terminal Illness

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

## Hospice Referrals

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

## Medications, Medical Equipment, and Supplies

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

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

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

## Short-Term Inpatient Care

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

Short-term inpatient care is considered acute care hospitalization.

## Skilled Nursing Services

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

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

## Counseling Services

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

Dietary counseling by a qualified [participating provider](#) must also be provided when needed.

## Bereavement Counseling

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

## Period of Crisis

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

## Respite Care

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

## Volunteer Services

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

## Claims Submission

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

All hospice claims submitted to Health Net for payment must be identified as hospice claims, as some services provided through hospice (for example, durable medical equipment (DME) and medications) may only be eligible through hospice coverage and not through other coverage under the member's plan.

The participating physician group (PPG) must inform both the hospice agency and the member that, regardless of the forms signed upon admission to a hospice program, the member is still required to have all non-hospice care directed, authorized and arranged for by a Health Net participating provider.

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To avoid rejections and delays in payment, all hospice providers are required to submit their claims with the member's signed election statement, the provider's certification of terminal illness, and the medical prognosis to the Health Net Claims Department.

## Hospice Agency

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

A hospice agency is an entity that provides hospice services to a terminally ill person and holds a current license as a hospice pursuant to Health and Safety Code section 1747, or a home health agency with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1.

## Interdisciplinary Team

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

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

The interdisciplinary team is the hospice care team, which is a physician-directed, nurse-coordinated interdisciplinary team comprised of social workers, counselors, clergy, physical and occupational therapists, and specially trained volunteers.

## Prior to Election of Hospice Services

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

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

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

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

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

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

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## Hospital and Skilled Nursing

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

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

Select any subject below:

- [Claims Submissions](#)
- [Inpatient Services and Skilled Nursing Facility Admissions](#)

## Claims Submissions

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

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

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

## Inpatient Services and Skilled Nursing Facility Admissions

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

## Inpatient Services

Inpatient services are covered on all Health Net plans. Services are covered with unlimited days per admission, subject to benefit calendar year maximums if applicable. Specifics regarding inpatient services are as follows:

- Inpatient services in a hospital, when medically necessary, are covered, subject to the scheduled copayments or coinsurance.
- Elective hospitalization of Health Net members is authorized by the participating physician group (PPG) if the member is affiliated with a capitated PPG that has responsibility for prudent hospital use. Services can be in an acute, general or specialized care hospital.
- [Participating providers](#) must contact Health Net or a Payor and the appropriate [primary care physician \(PCP\)](#) or PPG within 24 hours or by the next business day after a member is admitted

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into a hospital. Services may be in an acute, general or specialized care hospital. Inpatient days subsequent to this admission notification period are subject to authorization rules; failure to notify as set forth herein may result in denial of payment.

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

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

## Services in a Skilled Nursing Facility, Acute, Long-Term, or Psychiatric Hospital

All admissions and services rendered in a skilled nursing facility (SNF), acute rehabilitation, long-term care, or psychiatric unit or hospital, even if located in the acute hospital's structure, are considered separate admissions. These services are distinct from the acute hospital services and are paid independent of the acute hospital admission once the member is discharged from the hospital and admitted to the designated unit.

## Notification of SNF Admission and Discharge

To improve continuity and coordination of care for its members, Health Net requests that SNFs notify the member's PCP within 24 hours of admission to or discharge from a SNF.

When Health Net is the secondary payor and the member is admitted into a SNF or a long-term acute care (LTAC) facility, the facility needs to notify the plan upon admission or within 24 hours of exhaustion of the primary insurance. Health Net has a tracking system for members who are in facilities under a primary insurance, and notification is necessary to ensure that Medical Management has the ability to administer services for the member when Health Net becomes the primary payor.

To facilitate this process, Health Net has developed sample forms SNFs can use when notifying the member's PCP of an admission. If a SNF chooses to use its own notification forms, the following information must be included when notifying the member's PCP:

- Member name
- Identification (ID) number
- Date of birth (DOB)
- Admission date
- Admitting diagnosis
- Attending/admitting physician name
- Attending/admitting physician telephone and fax number
- Facility name
- Facility telephone and fax number
- Level of care

When notifying the member's PCP of a discharge from a SNF, the following information must be provided:

- Member name

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- ID number
- DOB
- Admission and discharge dates
- Attending physician name
- Attending physician telephone and fax number
- Diagnosis
- Follow-up appointment date, if known
- Discharge destination
- Responsible party at discharge
- Level of assistance
- Discharge planning needs including equipment, service or other special training needs
- Medications, including dosage and frequency at discharge
- Facility name, telephone number and fax number
- Level of care

For additional information regarding SNF notification, refer to the Hospital Notification Unit ([HMO](#) or [EPO and PPO](#)) documents under the Utilization Management topic.

## Immunizations

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

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

Select any subject below:

- [Coverage Explanation](#)

## Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

Medically necessary immunizations, as determined by Health Net are covered by all Health Net plans and include adult immunizations recommended by the Centers for Disease Control and Prevention (CDC) and childhood immunizations recommended by the American Academy of Pediatrics (AAP). Refer to the CDC website for:

- [The adult immunization schedule \(PDF\)](#).
- [The children and adolescents immunization schedule \(PDF\)](#).
- Some plans may also provide coverage for occupational-related requirements and foreign travel-related immunizations and may be subject to a copayment. Refer to the [Schedule of Benefits](#) for coverage and copayment information.

Most immunizations do not require a copayment. Refer to the [Schedule of Benefits](#) for exceptions.

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For employer group plans travel-related immunizations are covered fully or partially in accordance with the Provider Participation Agreement (PPA) for some Health Net commercial plans. Haemophilus influenza B (HIB) vaccines are also covered fully or partially in accordance with the PPA for some Health Net plans. These immunizations are usually subject to a copayment. Refer to the Schedule of Benefits for copayment information and exceptions.

Vaccines and immunizations may be sub-categorized as adult or pediatric according to the age of the member who receives the immunization.

## Incarcerated Members

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

## Coverage for Incarcerated Members

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

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

## 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:

- [Healthy Pregnancy](#)
- [Maternal Mental Health Screening Requirement](#)
- [Pediatric Services](#)



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## Healthy Pregnancy

Provider Type: Physicians | Participating Physician Groups (PPG)

The [Decision Power](#)® Healthy Pregnancy program educates women and provides screening to identify high-risk pregnancies. This program has been effective in prolonging pregnancies, improving birth weights and minimizing hospitalizations, by featuring the following:

- Initial assessment and risk screening, conducted at time of enrollment
- Online educational resources
- The book, *Your Journey Through Pregnancy*, which includes information from early pregnancy through the baby's first weeks, and a resource bookmark
- Access to [BabyLine](#)® - a telephone line answered by highly experienced nurses, 24 hours a day, seven days a week, for questions related to pregnancy
- Second assessment at approximately 28 weeks
- Referrals to case management for those at-risk participants identified during assessments
- Final assessment completed post-delivery
- Assessment report for participants and their physicians

Pregnant members identified as high risk and enrolled in the high-risk obstetric case management program have access to the expertise and experience of high-risk obstetric nurse case managers who are available to program participants 24 hours a day, seven days a week. The case manager creates a care plan unique for each participant by helping to set goals and develop strategies to assist the participant. Case managers also coordinate home-care and neonatal intensive care unit (NICU) care as needed. [Refer](#) eligible Health Net expectant mothers to this program via [fax](#).

## 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 in maternal blood, (trisomy 13, 18 and 21)
- Fetal aneuploidy (trisomy 13, 18 and 21), DNA sequence analysis of selected regions using maternal plasma

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.

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

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

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

## Maternal Mental Health Screening Requirement

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

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

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

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

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

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

## Pregnancy Program

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

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

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





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## Pediatric Services

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

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

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

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

## Medical Social Services

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

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

Select any subject below:

- [Coverage Explanation](#)

## Coverage Explanation

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

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

## Nuclear Medicine

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

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

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

## Nurse Midwife

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

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

Select any subject below:

- [Coverage](#)

## Coverage

Provider Type: Physicians

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

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

## Obesity

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

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

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

## Coverage

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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 [Decision Power® program](#).

For more information on, select any subject below:

[Bariatric Surgery Services](#)

## Bariatric Surgery Services

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

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

## Outpatient Services

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

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This section contains general member benefit information on outpatient services.

Select any subject below:

- [Coverage Explanation](#)

## 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).

## Periodic Health Evaluations

Provider Type: Physicians | Participating Physician Groups (PPG)

Coverage for periodic health evaluations and diagnostic preventive procedures is based on recommendations published by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC). They include female breast and pelvic exams, Pap smears, blood pressure checks, periodic check-ups, routine preventive care, newborn care office visits, and well-baby care.

Annual cervical cancer screenings are covered, which include Pap smear and the option of any cervical cancer test approved by the U.S. Food and Drug Administration (FDA) upon referral of the member's physician, nurse practitioner or certified nurse midwife, or by self-referral to an OB/GYN or family practice physician who provides such services within the member's participating physician group (PPG). In accordance with California legislation SB 1245 (ch.482, 2006), annual cervical cancer screening must also include coverage for FDA-approved human papillomavirus (HPV) screening.

## Preventive Services

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

This section contains general member benefit information on preventive care services.

Select any subject below:

- [Breast Cancer Susceptibility Gene Testing](#)
- [Hepatitis C Screening](#)
- [Mammography](#)
- [Preventive Services Guidelines](#)

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](http://providerlibrary.healthnetcalifornia.com)

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# Breast Cancer Susceptibility Gene Testing

Provider Type: Physicians

Health Net covers breast cancer susceptibility gene (BRCA) testing as preventive care for high-risk members enrolled in non-grandfathered health plans.

For information on Health Net's criteria for BRCA testing, refer to Health Net's medical policy, Genetic Testing for BRCA1 and BRCA2, available on the [Health Net provider website](#) > Medical Policies under Resources for You.

# Hepatitis C Screening

Provider Type: Physicians

Health Net covers hepatitis C virus (HCV) screening as preventive care for high-risk members enrolled in non-grandfathered health plans.

# Mammography

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

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) cover conventional 2-D mammography for commercial members in accordance with the member's health plan policy and the [Women's Preventive Services Guidelines – Health Resources & Services Administration](#).

Health Net covers 3-D mammography, also known as digital breast tomosynthesis (DBT), for HMO, Point of Service (POS), HSP, PPO, and EPO (commercial) plans. Claims codes affected by this change are listed below.

When administered as a preventive screening, this benefit is subject to the annual screening limit, and cost-shares do not apply. If DBT services are provided for diagnostic purposes outside of the annual screening, they do not require prior authorization, but are subject to the member's applicable cost-share.

Claims coding for DBT:

| CPT Codes | Description                              |
|-----------|--|
| 77061     | Digital breast tomosynthesis; unilateral |
| 77062     | Digital breast tomosynthesis; bilateral  |

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| CPT Codes   | Description  |
|-------------|--|
| 77063       | Screening digital breast tomosynthesis, bilateral                |
| HCCPS Codes | Description  |
| G0279       | Diagnostic digital breast tomosynthesis, unilateral or bilateral |

## Preventive Services Guidelines

Provider Type: Physicians | Participating Physician Groups (PPG)

Preventive care refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. Preventive care includes, but is not limited to, immunizations, medications, contraception, tobacco cessation treatment, examinations and screening tests tailored to an individual’s age, health and family history.

Health Net provides coverage for preventive care in accordance with the requirements of the Affordable Care Act (ACA). According to the ACA, preventive care services must include the following:

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

As new preventive care recommendations/guidelines are released by the USPSTF, ACIP and HRSA, they will ultimately be added to our list of covered preventive care benefits. *Note: All newly released preventive care recommendations/guidelines must be applicable to group health plans and health insurance issuers for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.*

On our commercial individual & family, small and large group plans, with the exception of grandfathered plans<sup>1</sup>, preventive care benefits obtained from an in-network provider are covered without member cost share (i.e., covered in full – without a deductible, coinsurance or copayment). Please keep in mind, certain covered services can be performed for preventive or diagnostic reasons (e.g., mammograms). Therefore, how such services are billed – preventive or diagnostic – will determine the applicable benefit category and cost share.

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Furthermore, if preventive and diagnostic services are performed during the same visit, cost share may apply to the latter (depending on the plan design).

Refer to the following websites for the most up-to-date information about preventive care coverage requirements:

- [USPSTF](#)
- [CDC ACIP](#)
  - [Recommended Child and Adolescent Immunization Schedule \(PDF\)](#)
  - [Recommended Adult Immunization Schedule \(PDF\)](#)
- [HRSA](#)
- [HealthCare.gov](#)

<sup>1</sup>Grandfathered plans are those that were in existence on March 23, 2010, and have stayed basically the same. Grandfathered plans are not required to provide all of the benefits and consumer protections required by the ACA. As such, Health Net's in-network preventive care, provided on these plans, does not have to be covered in full.

## Prosthesis

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

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

Select any subject below:

- [Phenylketonuria](#)

## Phenylketonuria

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

Health Net covers the testing and treatment of phenylketonuria (PKU). Treatment includes formulas and special food products that are part of a diet prescribed by a participating licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease. Coverage is only required to the extent that the cost of necessary formulas and foods exceeds the cost of a normal diet.

According to Health and Safety Code 1374.56 and Insurance Code 10123.89, formula means an enteral product for use at home that is prescribed by a physician or nurse practitioner or ordered by a registered dietitian upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of PKU.

Special food products means a food that is both:

- Prescribed for treatment of PKU consistent with recommendations and best practices in care and treatment of PKU (it does not include a food that is naturally low in protein, but may include food that is specially formulated to have less than one gram of protein per serving).

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- Used in place of normal food products, such as foods from the grocery store that are used by the general population.

For additional information regarding the coverage of treatment of PKU, refer to the [Coverage Explanation](#) document.

## Coverage Explanation

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

Prostheses are covered on most plans. Prostheses needs may be referred to any Health Net [participating provider](#).

Prostheses and supplies include:

- Artificial limbs
- Artificial eyes
- Artificial larynx devices after a laryngectomy
- Breast prostheses
- Colostomy and ostomy supplies
- Contact lenses after cataract surgery
- C.V., midline and peripheral catheters
- Enteral supplies (including formula)
- Lymphedema sleeves and gloves
- Phenylketonuria (PKU) formulas and food products
- Tracheostomy supplies
- Ventilator supplies

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

Repair or replacement of prostheses is covered. Repair or replacement due to misuse or loss is not covered. Supplies required for prostheses maintenance are covered.

Formula is covered under the prostheses benefit as follows:

- When given by a feeding tube
- When given for severe metabolic disorders (for example, PKU), whether by mouth or a feeding tube (as outlined in Health and Safety Code 1374.56 and Insurance Code 10123.89)

## Rehabilitation Therapy

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

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

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Select any subject below:

- [Coverage Explanation](#)
- [Home Health Services](#)
- [Physical, Occupational or Speech Therapy Services Concurrent Review Forms](#)

## Coverage Explanation

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

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

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

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

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

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

## Home Health Services

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

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

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

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# Physical, Occupational or Speech Therapy Services Concurrent Review Forms

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

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

## Support for Disabled Members

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

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

Select any subject below:

- [Americans with Disabilities Act of 1990](#)
- [Auxiliary Aids and Services](#)
- [Effective Communication](#)
- [Financial Responsibility](#)

## Americans with Disabilities Act of 1990

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

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

## Auxiliary Aids and Services

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



**Participating providers** are required to take steps to ensure that no person with a disability is excluded, denied services, segregated, or otherwise treated differently. Health Net provides American Sign Language and closed captioning interpreters upon request and at no cost for members with disabilities. Providers can request interpreter support for members with hearing impairment by calling the Health Net Provider Services Department.

In order to be excused from providing auxiliary aids and services to those with disabilities, health care providers must demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden.

## 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.

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- The type of operation or operations of any parent corporation or entity, including the composition, structure and functions of the workforce of the parent corporation or entity.

## Surgery, Surgical Supplies, and Anesthesia

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

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

Select any subject below:

- [Coverage Explanation](#)
- [Exclusions and Limitations](#)

## Coverage Explanation

Provider Type: Physicians | Hospitals

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

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

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

Refer to the [Schedule of Benefits](#) for specific plan coverage information.

## Exclusions and Limitations

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

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



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 CMC EPO 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).

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## Transgender Services

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

Medically necessary transgender services for treatment of gender identity disorder (GID) are covered benefits for Health Net members. Refer to the most current Standards of Care (SOC) and guidance located on the World Professional Association for Transgender Health (WPATH) website at [www.wpath.org](http://www.wpath.org) for clinical guidance. Additional clinical information is located on the [Health Net provider website](#), under Resources for you, select *Medical Policies > Gender Affirming Procedures (PDF)*.

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

- Consultation with transgender service providers.
- Transgender services work-up and preparation.
- Psychotherapy.
- Continuous hormonal therapy.
- Laboratory testing to monitor hormone therapy.
- Gender reassignment surgery that is not cosmetic in nature.

## Medically Necessary/Reconstructive Surgery

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

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Electrolysis
- Facial bone reduction
- Facial feminization
- Hair removal
- Hair transplantation
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Subcutaneous mastectomy
- Voice modification surgery

Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body... to create a normal appearance to the extent possible." (Insurance Code Section 10123.88(c)). In the case of transgender patients, "normal appearance" is to be determined by referencing the gender with which the patient identifies.

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Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance." (Insurance Code Section 10123.88(d)).

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

For example, with respect to hair removal through electrolysis, laser treatment, or waxing, the WPATH clarifies that patients with the same condition do not always respond to, or thrive, following the application of identical treatments. Treatment must be individualized, such as with the various hair removal techniques, and medical necessity should be determined according to the judgment of a qualified mental health professional and referring physician. The documentation to support the medical necessity for hair removal should include three essential elements:

1. A properly trained (in behavioral health) and competent (in assessment of gender dysphoria) professional has diagnosed the member with gender dysphoria or GID.
2. The individual is under feminizing hormonal therapy.
3. The medical necessity for hair removal has been determined according to the judgment of a qualified mental health professional and the referring physician.

If any element remains to be satisfied before medical necessity can be determined, the individual should be directed to an appropriate network participating provider for consultation or treatment.

## Requesting Services

Prior authorization is required for transgender services. Providers must submit clinically relevant information for medical necessity review with prior authorization request. Members may select an available transgender surgery specialist from Health Net's network. To find out which providers contract with Health Net to perform services in conjunction with transgender reassignment surgery, or if Health Net contracts with additional transgender reassignment surgeons, contact the [Health Net Provider Services Department](#).

## Transplants

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

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

Select any subject below:

- [Overview](#)
- [Compliance for Transplant Performance Centers Standardized Process](#)
- [Health Net Transplant Performance Centers](#)

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## Prior Authorization

The following transplants are covered when prior authorization is obtained and when medically necessary:

- Cornea
- Heart
- Heart and lung
- Intestine
- Kidney
- Kidney and pancreas
- Pancreas
- Liver
- Lung (single or double)
- Allogeneic stem cell transplants
- Autologous stem cell transplants

## SOLID ORGAN TRANSPLANT REVIEW PROCEDURE PRIOR AUTHORIZATION

All covered transplant services must be provided by a Health Net Transplant Performance Center (Center). Transplant service requests are evaluated on a case-by-case basis and must be prior authorized through Health Net.

All major organ and bone marrow transplant (both allogeneic 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) or specialist will be returned, and the requestor will be informed to have the transplant center submit the request.

A PCP or specialist who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Health Net Transplant Performance Center (Center) for transplant evaluation. The Center must submit a prior authorization request for the evaluation to the Centene CTU through the provider portal, or via fax directly to the CTU at 833-769-1142. On receipt of a request for a transplant, the CTU contacts the Center to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number for the evaluation.

Once a member has completed an evaluation and is approved by the Center for transplant, the Center must submit a prior authorization request for listing to the CTU through the provider portal, or via fax directly to the CTU at 833-769-1142. On receipt of a request for a listing, the CTU contacts the center or other provider to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number.

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

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

## 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

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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         |

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| Transplant Type        | Adult                                       | Pediatric |
|------------------------|---|-----------|
| Pancreas or SPK        | No minimum if kidney meets                  | N/A       |
| Intestinal/Small Bowel | 3   | 1         |
| Blood and Marrow       | 40 total, with at least 20 being allogeneic | 10        |

**Survival/Outcomes Criteria:**

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

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

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

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

**Blood and Marrow –**

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

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

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

# Health Net Transplant Performance Centers

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



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

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

## 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](#)
- [EyeMed Vision Care](#)

## Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

Vision examinations are covered, subject to the scheduled copayments. Coverage includes eye refractions and examinations for diagnosis or for correction of vision. Conventional glasses and contact lenses are not covered, unless the member's contract specifically provides for supplemental coverage with [EyeMed Vision Care](#). Vision services, including an annual vision exam and eyewear, are covered for pediatric members under age 19 (until at least the end of the month in which the enrollee turns 19 years of age) enrolled in a Health Net plan that includes vision coverage, as required by the Affordable Care Act (ACA). Pediatric vision coverage is administered by Eyemed Vision Care. For a list of additional covered vision services for these members, refer to the member's [Evidence of Coverage \(EOC\)](#), [Certificate of Insurance \(COI\)](#) or [Schedule of Benefits](#).

Intraocular lens implants to replace the organic eye lens are covered following cataract surgery. If an intraocular lens is not implanted following such surgery, then contact lenses or cataract eyeglasses are covered. Refer to the member's EOC, COI or Schedule of Benefits for specific plan information.

## Exclusions and Limitations

Refer to the member's [Evidence of Coverage \(EOC\)](#), [Certificate of Insurance \(COI\)](#) or [Schedule of Benefits](#) for additional information.

## EyeMed Vision Care

Provider Type: Physicians | Participating Physician Groups (PPG)

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Health Net contracts with [Centene Vision Services](#) to provide vision benefits to Health Net members whose coverage includes vision plan benefits. [Centene Vision Services](#) sub-delegates benefit administration to EyeMed Vision Care. [EyeMed](#) provides benefits for a routine vision exam and/or eyewear through their network of optometrists, dispensing opticians and optometric laboratories for employer and union groups as well as individual members (not covered through an employer group). Benefit coverage and benefit administration varies by plan:

- Exam only
- Materials only
- Exam and materials

Depending upon the plan the routine vision examination may be covered through their participating physician group (PPG) or primary care physician (PCP) or through EyeMed.

If the member requires eyeglasses, a prescription is written and the member may purchase eyewear from a list of participating dispensing opticians in California.

The optician bills EyeMed Vision Care for reimbursement. If the member selects standard lenses and frames, they do not owe the dispensing optician. If more costly items are selected, members are required to pay the amount in excess of those specified in the Schedule of Allowances under the member's [Evidence of Coverage](#) (EOC), or [Certificate of Insurance](#) (COI). The HMO member is required to obtain eyewear services only through participating providers.

## Eye Care Network Responsibilities

The PCP or PPG are not responsible for referring Health Net members to EyeMed Vision Care for a refraction examination when applicable; however, PCPs or PPGs should be aware of which members have this benefit so they can direct the member to contact [EyeMed Vision Care](#) when appropriate.

If the EyeMed Vision Care provider finds a medical problem during the refraction examination, the provider must refer the member back to the PCP or PPG. If the medical condition is considered acute or emergency, the provider must call the PPG and direct the member back to the PCP immediately or to a hospital emergency department, if appropriate. For non-emergency conditions, the provider prepares and sends a report to the PCP or PPG identifying the problem and instructs the member to follow up with their PCP for further evaluation and treatment.

A member with a Health Net vision plan can request an appointment for a vision examination through the PPG.

## Criteria for Vision Services

Eyewear services is not covered by individual family plans (IFP).

The HMO member is required to obtain eyewear services through participating providers. Refer to the member's [Evidence of Coverage](#) (EOC), [Certificate of Insurance](#) (COI) or [Schedule of Benefits](#) for additional information or contact Health Net vision plan.

A member with a Health Net vision plan can request an appointment for a vision examination through the participating physician group (PPG).



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# 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:

- [Diagnostic Procedures](#)
- [Laboratory Services](#)
- [Radiation Therapy](#)

## 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

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## Laboratory Services

Provider Type: Physicians

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

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

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

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

## Radiation Therapy

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

[eviCore healthcare](#) is responsible for the prior authorization process for radiation therapy for all members\*. Physicians and specialty providers can request prior authorization by contacting [eviCore healthcare](#).

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



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# Claims and Provider Reimbursement

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

This section describes claims and provider reimbursement

Select any subject below:

- [Remittance Advice and Explanation of Payment System](#)
- [Accessing Claims on Health Net Provider Portal](#)
- [Adjustments](#)
- [Balance Billing](#)
- [Billing and Submission](#)
- [Capitated Claims Billing Information](#)
- [Eligibility Guarantee](#)
- [Eligibility and Capitation](#)
- [Fee-For-Service Billing and Submission](#)
- [PPO Billing](#)
- [Premium Payment Grace Period for Beneficiary Qualifying for APTC](#)
- [Professional Claim Editing](#)
- [Refunds](#)
- [Reimbursement](#)
- [Reinsurance](#)
- [Salud con Health Net](#)
- [Schedule of Benefits and Summary of Benefits](#)
- [Timely Filing Criteria](#)
- [When Medicare is a Secondary Payer](#)

## Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

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

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

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

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

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

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

## Accessing Claims on the New Health Net Portal

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

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

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

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## 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 and Health Net's Provider Participation Agreement (PPA).

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

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

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

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

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

For more information, select any subject below:

- [15-Day Letters MEDI-CAL](#)
- [Billing Medicare/Medi-Cal Members Prohibited MEDICARE](#)
- [Fee Prohibitions MEDI-CAL](#)
- [Hold Harmless Provisions MEDICARE](#)
- [Missed Appointments MEDI-CAL](#)

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## Billing and Submission

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

This section contains general information on claims billing and submission.

Select any subject below:

- [Claims Receipt Acknowledgement](#)
- [Claims Submission](#)
- [Claims Submission Requirements](#)
- [Clinical Information Submission](#)
- [CMS-1500 Billing Instructions](#)
- [Health Savings Account](#)
- [Hospital Acquired Conditions](#)
- [Trauma Services](#)
- [UB-04 Billing Instructions](#)
- [Workers' Compensation](#)

## Claims Receipt Acknowledgement

Provider Type: Physicians | Ancillary | Hospitals

Health Net provides an acknowledgement of claims receipt, whether or not the claims are complete, within two business days for electronically submitted claims. For paper claims, Health Net provides an acknowledgement of claims receipt within 15 business days of receipt for HMO, Medi-Cal, PPO, and EPO. If a paper claim is paid or denied within 15 days, the Remittance Advice (RA) is considered an acknowledgement of claims receipt. A provider may obtain acknowledgement of claim receipt in the following manner:

**HMO, PPO, EPO, and HSP claims:** Electronic fax-back confirmation of claims receipt through the Health Net Provider Services Center interactive voice response (IVR) system, via a paper acknowledgement report mailed within 14 days of claims receipt and on the [Health Net provider portal](#).

**Medi-Cal claims:** Confirmation of claims receipt through the provider portal of [Health Net's website](#) and by calling the [Medi-Cal Provider Services Center](#), [Community Health Plan of Imperial Valley Provider Services Center](#) or [CalViva Health Provider Services Center](#).

Claims received from a provider's clearinghouse are acknowledged directly to the clearinghouse in the same manner and time frames noted above.

**Date of Receipt definition:** Date of receipt is the business day when a claim is first delivered, electronically or physically, to Health Net's designated address.



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## Claims Submission

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

Providers must use correct coding to ensure prompt, accurate processing of claims. Physicians should use CMS-1500 forms and CPT or HCPCS coding, as indicated in the Provider Participation Agreement (PPA). Hospitals use UB-04 (CMS-1450) form and current UB coding, including CPT, DRG, HCPCS, and ICD-10.

If the provider has more than one tax identification number, use the tax identification number under which the PPA has been signed and also include the National Provider Identifier (NPI) number. Claims cannot be processed without these identifying numbers.

The physician's name must be listed in the Referring Physician box on the claim form only if the member has received a referral from the primary care physician (PCP). Claims submitted with a physician's name in the Referring Physician box are processed at the Tier 1 (HMO) coverage level. Members accessing Tier 2 or Tier 3 coverage levels do not have a referral form from the PCP and the claim form needs to accurately reflect this.

Submit Health Net claims within 120 calendar days from the date of service to the [Health Net commercial claims address \(PPO\)](#). Do not send claims to members unless the member has agreed, in writing, to take financial responsibility for a non-covered service.

## Claims Submission Requirements

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

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

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

Refer to [un-clean claims](#) for more information.

## Acceptable Forms

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

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

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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](http://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](http://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](http://www.cms.gov).

## Mandatory Items for Claims Submission

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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           |

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| 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) |

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| 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<br>UB-04 box 10  | Section 2<br><sup>1</sup> 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<br>UB-04 box 60 | Section 2<br><sup>1</sup> Non-standard submission or equivalent |

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| 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<br>UB-04 box 5  | Section 1a<br><sup>1</sup> Non-standard submission or equivalent    |
| 17          | Diagnosis indicator is missing<br><br>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.<br><br>Ensure present on admission (POA) indicators are valid when billed.<br><br>Ensure a valid DRG code is used in field 71. POA valid values are:<br><br>Y – Diagnosis was present at time of inpatient admission.<br><br>N – Diagnosis was not present at time of inpatient admission.<br><br>Leave blank if cannot be determined | UB-04 box 66-70<br>UB-04 box 71 | Section 3<br><br><sup>1</sup> 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   |

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| 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 <a href="#">Medi-Cal Provider Contested Claims</a> . | CMS-1500 box 22<br>UB-04 box 4 and 64 | Section 4<br><br><sup>1</sup> 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   |

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| Reject code | Reject reason  | Requirements  | CMS-1500 or UB-04                        | ECM and Community Supports Invoice Claim Form                    |
|-------------|--|---|--|--|
|             |  | <p>the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows:</p> <p>1st digit – Indicating the type of facility<br/>                     2nd digit – Indicating the type of care<br/>                     3rd digit – Indicating the bill sequence (frequency code)</p> |  |  |
| 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<br>UB-04 box 56 | Section 1b<br><sup>1</sup> 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<br>UB-04 box 43         | N/A  |

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| 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.<br><br>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<br><br>UB-04 box 1   | Section 1a<br><br><sup>1</sup> 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<br><br>UB-04 box 64  | Section 4<br><br><sup>1</sup> 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   |

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| 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<br><br>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<br><br>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   |

<sup>1</sup>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.

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The documentation of each patient encounter should include the following:

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

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

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

## CMS-1500 Billing Instructions

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

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

| Field number | Field description                  | Instruction or comments   | Required, conditional or not required |
|--------------|------------------------------------|---|---------------------------------------|
| 1            | Insurance program identification   | Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being filed. Enter "X" in the box noted "Other" | Required                              |
| 1a           | Insured identification (ID) number | The nine-digit identification number on the member's ID card  | Required                              |

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| Field number | Field description   | Instruction or comments  | Required, conditional or not 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.<br><br>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)<br>Telephone number (include area code) | Enter the patient's complete address and telephone number, including area code on the appropriate line.<br><br>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).<br><br>Second line - In the designated block, enter the city and state.<br><br>Third line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP +4 | Conditional                                    |

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| Field number | Field description   | Instruction or comments  | Required, conditional or not required                  |
|--------------|---|--|--|
|              |   | <p>codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414.</p> <p>Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1</p>   |  |
| 6            | Patient's relationship to insured   | Always mark to indicate self if the same   | Conditional - Always mark to indicate self if the same |
| 7            | <p>Insured's address</p> <p>(number, street, city, state, ZIP code)</p> <p>Telephone number (include area code)</p> | <p>Enter the insured's complete address and telephone number, including area code on the appropriate line.</p> <p>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.</p> <p>Second line - In the designated block, enter the city and state.</p> <p>Third line - Enter the ZIP code and telephone number.</p> | Conditional  |



| Field number | Field description  | Instruction or comments   | Required, conditional or not required  |
|--------------|--|---|--|
|              |  | <p>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.</p> <p>Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1</p> |  |
| 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  | <p>Conditional refers to someone other than the patient.</p> <p>REQUIRED if patient is covered by another insurance plan</p> |
| 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  | <p>Conditional</p> <p>REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan</p>    |
| 9b           | Reserved for NUCC  | N/A   | Not required   |
| 9c           | Reserved for NUCC  | N/A   | Not required   |
| 9d           | Insurance plan name or program name                          | REQUIRED if field 9 is completed. Enter the   | Conditional  |

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| Field number | Field description                  | Instruction or comments   | Required, conditional or not required                     |
|--------------|------------------------------------|---|---|
|              |                                    | other insured's (name of person listed in field 9) insurance plan or program name   | 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<br>REQUIRED when other insurance is available |
| 11a          | Insured date of birth and sex      | Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank     | Conditional   |

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| Field number | Field description                          | Instruction or comments  | Required, conditional or not required   |
|--------------|--|--|---|
| 11b          | Other claims ID (Designated by NUCC)       | <p>The following qualifier and accompanying identifier has been designated for use:</p> <p>Y4 Property Casualty Claim Number</p> <p>For worker's compensation of property and casualty: Required if known.</p> <p>Enter the claim number assigned by the payer</p>       | 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 to process and/or adjudicate the claim | Conditional - Enter "Signature on File," "SOF," or the actual legal signature |



| Field number | Field description   | Instruction or comments  | Required, conditional or not required |
|--------------|---|--|---------------------------------------|
| 13           | Insured's or authorized person's signature  | Obtain signature if appropriate.   | Not required                          |
| 14           | Date of current:<br>Illness (First symptom) or<br>Injury (Accident) or<br>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.<br><br>Enter the applicable qualifier to identify which date is being reported.<br><br>431 Onset of Current Symptoms or Illness<br><br>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                           |
| 16           | Dates patient unable to work in current occupation  | Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY)   | Conditional                           |



| Field number | Field description   | Instruction or comments  | Required, conditional or not required  |
|--------------|---|--|--|
| 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<br>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<br>REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used                   |
| 18           | Hospitalization on dates related to current services  |  | Conditional  |
| 19           | Reserved for local use - new form: Additional claim information   |  | Conditional  |
| 20           | Outside lab/ charges  |  | Conditional  |
| 21           | Diagnosis or nature of illness or injury (related items A-L to item 24E by line). New form allows up to 12 diagnoses, and ICD indicator | Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. | Required - Include the ICD indicator   |

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| Field number | Field description                         | Instruction or comments   | Required, conditional or not required  |
|--------------|---|---|--|
|              |   | 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:<br><br>- Replacement of Prior Claim<br><br>- 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.<br><br>CLIA number for CLIA waived or CLIA certified laboratory services | If authorization, then conditional If CLIA, then required If both, submit the CLIA number<br><br>Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization.<br><br>CLIA number for CLIA waived or CLIA certified laboratory services |



| Field number  | Field description        | Instruction or comments  | Required, conditional or not required  |
|---------------|--------------------------|--|--|
| 24 A-G Shaded | Supplemental information | <p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <ul style="list-style-type: none"> <li>• NDC</li> <li>• Narrative description of unspecified codes</li> <li>• Contract rate</li> <li>• For detailed instructions and qualifiers refer to Appendix IV of this guide</li> </ul> | <p>Conditional - The shaded top portion of each service claim line is used to report supplemental information for:</p> <p>NDC</p> <p>Narrative description of unspecified codes</p> <p>Contract rate</p> |
| 24A Unshaded  | Dates of service         | <p>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</p>  | Required   |
| 24B Unshaded  | Place of service         | <p>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</p>   | Required   |

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| Field number  | Field description                                    | Instruction or comments   | Required, conditional or not 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 | <p>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.</p> <p>Codes entered must be valid for date of service.</p> <p>Missing or invalid codes will be denied for payment.</p> <p>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</p> | Required - Ensure NDC or UPIN is included if applicable |
| 24 E Unshaded | Diagnosis code                                       | In 24E, enter the diagnosis code reference letter (pointer) as shown in box 21 to relate the date of service and the procedures performed to the  | Required  |

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| Field number  | Field description | Instruction or comments   | Required, conditional or not required |
|---------------|-------------------|---|---------------------------------------|
|               |                   | <p>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</p> |                                       |
| 24 F Unshaded | Charges           | <p>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line</p>   | Required                              |



| Field number  | Field description       | Instruction or comments  | Required, conditional or not required   |
|---------------|-------------------------|--|---|
| 24 G Unshaded | Days or units           | Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one   | Required  |
| 24 H Shaded   | EPSDT (Family Planning) | Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral   | Conditional - Leave blank or enter "Y" if the services were performed as a result of an Early and Periodic Screening, Diagnostic and 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#    | <u>Typical providers:</u><br>Enter the provider taxonomy code that corresponds to the qualifier entered in box 24I shaded. Use ZZ qualifier for taxonomy code<br><br><u>Atypical providers:</u><br>Enter the provider ID number. | Required  |
| 24 J Unshaded | NPI provider            | <u>Typical providers ONLY:</u> Enter the 10-character NPI of the   | Required  |

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| Field number | Field description             | Instruction or comments  | Required, conditional or not required  |
|--------------|-------------------------------|--|--|
|              | ID                            | 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) |  |
| 25           | Federal Tax ID number SSN/EIN | Enter the provider or supplier nine-digit federal tax ID number, and mark the box labeled EIN  | Required   |
| 26           | Patient's account NO          | Enter the provider's billing account number  | Conditional - Enter the provider's billing account number  |
| 27           | Accept Assignment?            | Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS-1500 (02-12) claim form for the section pertaining to payments  | Conditional - Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment |

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| Field number | Field description | Instruction or comments  | Required, conditional or not required   |
|--------------|-------------------|--|---|
| 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.<br><br>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<br><br>REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing |
| 30           | Balance due       | REQUIRED when field 29 is completed. Enter the balance due (total  | Conditional   |

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| Field number | Field description   | Instruction or comments   | Required, conditional or not required   |
|--------------|---|---|---|
|              |   | <p>charges minus the amount of payment received from the primary payer).</p> <p>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</p> | <p>REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)</p> |
| 31           | Signature of physician or supplier including degrees or credentials | <p>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.</p> <p>Note: Does not exist in the electronic 837P</p>   | Required  |
| 32           | Service facility location information                               | REQUIRED if the location where services were rendered is different from the billing   | <p>Conditional</p> <p>REQUIRED if the location where services were rendered is different</p>  |

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| Field number | Field description       | Instruction or comments  | Required, conditional or not required  |
|--------------|-------------------------|--|--|
|              |                         | <p>address listed in field 33.</p> <p>Enter the name and physical location. (PO box numbers are not acceptable here.)</p> <p>First line - Enter the business/facility/ practice name.</p> <p>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).</p> <p>Third line - In the designated block, enter the city and state.</p> <p>Fourth line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 codes), include the hyphen</p> | <p>from the billing address listed in field 33</p>   |
| 32a          | NPI - Services rendered | <p><u>Typical providers ONLY</u>: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p>  | <p>Conditional</p> <p><u>Typical providers ONLY</u>: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> |



| Field number | Field description           | Instruction or comments  | Required, conditional or not required  |
|--------------|-----------------------------|--|--|
| 32b          | Other provider ID           | <p>Enter the 10-character NPI of the facility where services were rendered.</p> <p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p><u>Typical providers:</u><br/>Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces).</p> <p><u>Atypical providers:</u><br/>Enter the 2-character qualifier 1D (no spaces)</p> | <p>Conditional</p> <p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33</p> |
| 33           | Billing provider INFO & PH# | <p>Enter the billing provider's complete name, address (include the ZIP + 4 code), and telephone number.</p> <p>First line -Enter the business/facility/ practice name.</p> <p>Second line - Enter the street address. Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101</p>   | <p>Required</p>  |

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| Field number | Field description      | Instruction or comments   | Required, conditional or not required |
|--------------|------------------------|---|---------------------------------------|
|              |                        | <p>instead of 123 N. Main Street, #101).</p> <p>Third line - In the designated block, enter the city and state.</p> <p>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).</p> <p>NOTE: The nine digit ZIP code (ZIP + 4 code) is a requirement for paper and EDI claim submission</p> |                                       |
| 33a          | Group billing NPI      | <p><u>Typical providers ONLY</u>: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI .</p>   | 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 |
|--------------|-------------------|---|---------------------------------------|
|              |                   | <p><u>Typical providers:</u><br/>Enter the provider taxonomy code. Use ZZ qualifier.</p> <p><u>Atypical providers:</u><br/>Enter the provider ID number</p> |                                       |

## Health Savings Account

Provider Type: Physicians | Hospitals | Ancillary

Participating providers rendering services to a Health Net member using a health savings account (HSA) should not collect deductibles, copayments or coinsurance at the time of service. Providers should bill Health Net first.

The following HSA claims processing procedures are in place to ensure proper reimbursement:

- Providers submit claims to Health Net within 120 calendar days from the date the services were rendered
  - Providers must bill Health Net first for the care provided
- Member responsibility is determined through the claim adjudication process under the terms of the medical plan
  - Upon receipt of the provider claim, Health Net determines the member's financial responsibility and communicates this to the provider through the Remittance Advice (RA)
  - The member receives the same information given to the provider in an Explanation of Benefits (EOB)
- Members may only be billed after the provider receives an RA
  - Collecting any payments owed by the member after the provider receives an RA ensures accurate collection and prevents future refunds due to excess money collected
- Members may pay by Wells Fargo Visa<sup>®</sup> debit card, credit card, check, or cash

Providers may not collect more than the contracting rate for services provided, regardless of the member's outstanding financial obligation.

## Hospital Acquired Conditions

Provider Type: Hospitals

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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 occurred. 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](http://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          |

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| Indicator | Description   |
|-----------|---|
|           | 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

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

## Trauma Services

Provider Type: Hospitals

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

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

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

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

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

## UB-04 Billing Instructions

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

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

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| 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<br><br>**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                              |

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| Field number | Field description                    | Instruction or comments  | Required, conditional or not required |
|--------------|--------------------------------------|--|---------------------------------------|
|              |                                      | <p>be reflected as follows:</p> <p>1st Digit - Indicating the type of facility. 2nd Digit - Indicating the type of care. 3rd Digit- Indicating the bill sequence (frequency code).</p>   |                                       |
| 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                          |

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

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| 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.<br><br>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.<br><br><ul style="list-style-type: none"> <li>• 00 - 12:00 a.m.</li> <li>• 01 - 1:00 a.m.</li> <li>• 02 - 2:00 a.m.</li> <li>• 03 - 3:00 a.m.</li> <li>• 04 - 4:00 a.m.</li> <li>• 05 - 5:00 a.m.</li> <li>• 06 - 6:00 a.m.</li> <li>• 07 - 7:00 a.m.</li> <li>• 08 - 8:00 a..m</li> <li>• 09 - 9:00 a.m.</li> <li>• 10 - 10:00 a.m.</li> <li>• 11 - 11:00 a.m.</li> <li>• 12 - 12:00 p.m.</li> <li>• 13 - 1:00 p.m.</li> </ul> | Required for Inpatient claims. Leave blank for Outpatient claims.<br><br>Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated. |

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| Field number | Field description | Instruction or comments   | Required, conditional or not required |
|--------------|-------------------|---|---------------------------------------|
|              |                   | <ul style="list-style-type: none"> <li>• 14 - 2:00 p.m.</li> <li>15 - 3:00 p.m.</li> <li>• 16 - 4:00 p.m.</li> <li>17 - 5:00 p.m.</li> <li>• 18 - 6:00 p.m.</li> <li>19 - 7:00 p.m.</li> <li>• 20 - 8:00 p.m.</li> <li>21 - 9:00 p.m.</li> <li>• 22 - 10:00 p.m.</li> <li>23 - 11:00 p.m.</li> </ul>                      |                                       |
| 14           | Admission type    | <p>Require for inpatient and outpatient admissions. Enter the one-digit code indicating the type of the admission using the appropriate following codes:</p> <ul style="list-style-type: none"> <li>• 1 - Emergency</li> <li>• 2 - Urgent</li> <li>• 3 - Elective</li> <li>• 4 - Newborn</li> <li>• 5 - Trauma</li> </ul> | Required                              |
| 15           | Admission source  | <p>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.</p> <p>For type of admission 1,2,3, or 5:</p> <ul style="list-style-type: none"> <li>• 1 - Physician referral</li> </ul>                     | Required                              |



| Field number | Field description | Instruction or comments  | Required, conditional or not required   |
|--------------|-------------------|--|---|
|              |                   | <ul style="list-style-type: none"> <li>• 2 - Clinic referral</li> <li>• 3 - Health maintenance referral (HMO)</li> <li>• 4 - Transfer from a hospital</li> <li>• 5 - Transfer from skilled nursing facility</li> <li>• 6 - Transfer from another health care facility</li> <li>• 7 - Emergency room</li> <li>• 8 - Court/law enforcement</li> <li>• 9 - Information not available</li> </ul> <p>For type of admission 4 (newborn):</p> <ul style="list-style-type: none"> <li>• 1 - Normal delivery</li> <li>• 2 - Premature delivery</li> <li>• 3 - Sick baby</li> <li>• 4 - Extramural birth</li> <li>• Information not available</li> </ul> |   |
| 16           | Discharge hour    | <p>Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge.</p> <ul style="list-style-type: none"> <li>• 00 - 12:00 a.m.</li> <li>• 01 - 1:00 a.m.</li> </ul>  | 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 |
|--------------|-------------------|---|---------------------------------------|
|              |                   | <ul style="list-style-type: none"> <li>• 02 - 2:00 a.m.</li> <li>03 - 3:00 a.m.</li> <li>• 04 - 4:00 a.m.</li> <li>05 - 5:00 a.m.</li> <li>• 06 - 6:00 a.m.</li> <li>07 - 7:00 a.m.</li> <li>• 08 - 8:00 a.m.</li> <li>09 - 9:00 a.m.</li> <li>• 10 - 10:00 a.m.</li> <li>11 - 11:00 a.m.</li> <li>• 12 - 12:00 p.m.</li> <li>13 - 1:00 p.m.</li> <li>• 14 - 2:00 p.m.</li> <li>15 - 3:00 p.m.</li> <li>• 16 - 4:00 p.m.</li> <li>17 - 5:00 p.m.</li> <li>• 18 - 6:00 p.m.</li> <li>19 - 7:00 p.m.</li> <li>• 20 - 8:00 p.m.</li> <li>21 - 9:00 p.m.</li> <li>• 22 - 10:00 p.m.</li> <li>23 - 11:00 p.m.</li> </ul> |                                       |
| 17           | Patient status    | <p>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:</p> <ul style="list-style-type: none"> <li>• 01 - Routine discharge</li> <li>• 02 - Discharged to another short-term general hospital</li> <li>• 03 - Discharged to SNF</li> </ul>  | Required                              |



| Field number | Field description | Instruction or comments  | Required, conditional or not required |
|--------------|-------------------|--|---------------------------------------|
|              |                   | <ul style="list-style-type: none"> <li>• 04 - Discharged to ICF</li> <li>• 05 - Discharged to another type of institution</li> <li>• 06 - Discharged to care of home health service organization</li> <li>• 07 - Left against medical advice</li> <li>• 09 - Discharged/ transferred to home under care of a home IV provider</li> <li>• 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)</li> <li>• 20 - Expired or did not recover</li> <li>• 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)</li> <li>• 40 - Expired at home (hospice use only)</li> <li>• 41 - Expired in a medical facility (hospice use only)</li> <li>• 42 - Expired- place unknown</li> </ul> |                                       |

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| Field number | Field description | Instruction or comments  | Required, conditional or not required |
|--------------|-------------------|--|---------------------------------------|
|              |                   | <p>(hospice use only)</p> <ul style="list-style-type: none"> <li>• 43 - Discharged/ transferred to a federal hospital (such as a Veteran's Administration [VA] hospital)</li> <li>• 50 - Hospice-Home</li> <li>• 51 - Hospice-Medical Facility</li> <li>• 61 - Discharged/ transferred within this institution to a hospital-based Medicare approved swing bed</li> <li>• 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital</li> <li>• 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH)</li> <li>• 64 - Discharged/ transferred to a nursing facility</li> </ul> |                                       |

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| Field number | Field description | Instruction or comments   | Required, conditional or not required   |
|--------------|-------------------|---|---|
|              |                   | certified under Medicaid but not certified under Medicare <ul style="list-style-type: none"> <li>• 65 - Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</li> <li>• 66 - Discharged/ transferred to a critical access hospital (CAH)</li> </ul>  |   |
| 18-28        | Condition codes   | <p>REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing.</p> <p>Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual</p> | <p>Conditional</p> <p>REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing</p> |
| 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      | <p>Occurrence code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>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</p> | <p>Conditional</p> <p>REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing</p> |
| 35-36 a-b    | Occurrence SPAN code and Occurrence date | <p>Occurrence span code: REQUIRED when applicable. Occurrence codes are</p>  | <p>Conditional</p> <p>REQUIRED when occurrence codes are</p>   |

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

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| Field number | Field description       | Instruction or comments   | Required, conditional or not required   |
|--------------|-------------------------|---|---|
| 39-41 a-d    | Value codes and amounts | <p>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).</p> <p>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.</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>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 (\$)</p> | <p>Conditional</p> <p>REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing</p> |

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| 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            | <p>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.</p> <p>Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value</p> | 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) |

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| Field number  | Field description | Instruction or comments  | Required, conditional or not required   |
|---------------|-------------------|--|---|
|               |                   | <p>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)</p>  |   |
| 44 lines 1-22 | HCPCS/Rates       | <p>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).</p> <p>Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>Please refer to your current provider contract</p> | <p>Conditional</p> <p>REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed</p> |
| 45 Lines 1-22 | Service date      | <p>REQUIRED on all outpatient claims. Enter the date of service for each</p>   | <p>Conditional</p> <p>REQUIRED on all outpatient claims. Enter the date of</p>  |

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| 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 |

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| 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.<br><br>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   |

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| 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.<br><br>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  |

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| 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      | <p>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</p> <p>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).</p> <p>*Please refer to the reconsider/corrected claims section</p> | 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 |

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| 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<br>A-Q    | Other diagnosis code     | <p>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 &amp; 3 for the date of service.</p> <p>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.</p> <p>Note: Claims with incomplete or invalid</p> | Conditional - Enter additional diagnosis or conditions that coexist at the time of admission |

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| 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       | <p>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 &amp; 3 for the date of service.</p> <p>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.</p> <p>Note: Claims with missing or invalid diagnosis codes will be denied</p> | 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                              |

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| Field number | Field description             | Instruction or comments   | Required, conditional or not required   |
|--------------|-------------------------------|---|---|
|              |                               | <p>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.</p> <p>NOTE: Claims with missing or invalid diagnosis codes will be denied</p> |   |
| 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 | <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>                        | <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY)</p> |
| 74 a-e       | Other procedure code date     | REQUIRED on inpatient claims when a procedure is  | <p>Conditional</p> <p>REQUIRED on inpatient claims when</p>   |

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| Field number | Field description   | Instruction or comments  | Required, conditional or not required                     |
|--------------|---------------------|--|---|
|              |                     | <p>performed during the date span of the bill.</p> <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p> | a procedure is performed during the date span of the bill |
| 75           | Unlabeled field     | N/A  | Not required  |
| 76           | Attending physician | <p>Enter the NPI and name of the physician in charge of the patient care.</p> <ul style="list-style-type: none"> <li>• NPI: Enter the attending physician 10-character NPI ID.</li> <li>• Taxonomy code: Enter valid taxonomy code.</li> <li>• QUAL: Enter one of the following</li> </ul>   | Required  |



| Field number | Field description   | Instruction or comments   | Required, conditional or not required   |
|--------------|---------------------|---|---|
|              |                     | qualifier and ID number:<br><br><ul style="list-style-type: none"> <li>• 0B - State license #.</li> <li>• 1G - Provider UPIN.</li> <li>• G2 - Provider commercial #.</li> <li>• B3 - Taxonomy code.</li> <li>• LAST: Enter the attending physician's last name.</li> <li>• FIRST: Enter the attending physician's first name</li> </ul>                                     |   |
| 77           | Operating physician | REQUIRED when a surgical procedure is performed.<br><br>Enter the NPI and name of the physician in charge of the patient care.<br><br><ul style="list-style-type: none"> <li>• NPI: Enter the attending physician 10-character NPI ID.</li> <li>• Taxonomy code: Enter valid taxonomy code.</li> <li>• QUAL: Enter one of the following qualifier and ID number:</li> </ul> | Conditional<br><br>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 |
|--------------|-------------------|--|---------------------------------------|
|              |                   | <ul style="list-style-type: none"> <li>• 0B - State license #.</li> <li>• 1G - Provider UPIN.</li> <li>• G2 - Provider commercial #.</li> <li>• B3 - Taxonomy code.</li> <li>• LAST: Enter the attending physician's last name.</li> <li>• FIRST: Enter the attending physician's first name.</li> </ul>   |                                       |
| 78 & 79      | Other physician   | <p>Enter the provider type qualifier, NPI and name of the physician in charge of the patient care.</p> <ul style="list-style-type: none"> <li>• (Blank Field): Enter one of the following provider type qualifiers:</li> <li>• DN - Referring provider.</li> <li>• ZZ - Other operating MD.</li> <li>• 82 - Rendering provider.</li> <li>• NPI: Enter the other physician 10-character NPI ID.</li> <li>• QUAL: Enter one of the following qualifier and ID</li> </ul> | Conditional                           |



| Field number | Field description   | Instruction or comments  | Required, conditional or not required |
|--------------|---------------------|--|---------------------------------------|
|              |                     | number, or 0B - State license number<br><ul style="list-style-type: none"> <li>• 1G - Provider UPIN number</li> <li>• G2 - Provider commercial number</li> </ul> |                                       |
| 80           | Remarks             | N/A  | Not required                          |
| 81           | CC                  | A: Taxonomy of billing provider. Use B3 qualifier.   | Required                              |
| 82           | Attending Physician | Enter name or seven-digit provider number of ordering physician  | Required                              |

## Workers' Compensation

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

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

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

## Capitated Claims Billing Information

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

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

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

## Capitated Risk Claims

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

## Electronically Submitted Claims

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

## EOC 300/308 Report

### Denied Claims

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

The Health Net Medi-Cal Claims Department sends a weekly report to any provider who has submitted claims to Health Net that are denied by Health Net as services capitated to a participating physician group (PPG) or hospital. The report provides the name and telephone number of the PPG or hospital to which the denied claims have been forwarded for processing.

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

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

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

### Field Descriptions

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

### Header Information

| #   | Field              | Description   |
|-----|--------------------|---|
| 1.  | ABS                | Health Net's operating system   |
| 2.  | Program ID         | Health Net's assigned number for the report   |
| 4.  | Claim Type         | Facility = UB-04 form<br>Professional = CMS-1500 form   |
| 4.  | Report Title       | The name of the report  |
| 5.  | Run Date           | The day/month/year that the report was generated  |
| 6.  | Run Time           | The time that the report was generated  |
| 7.  | Page Number        | The page number of the report   |
| 8.  | Remit Num          | A 14-digit internal number that gives information about the claim's financial status                              |
| 9.  | Check Date         | The date of the check issued to a provider for claim payment  |
| 10. | Servicing Provider | The TIN and name of the provider who submitted the claim to Health Net for payment                                |
| 11. | Pay To             | The name of the group that the Servicing Provider is linked to. The Servicing Provider and Pay To can be the same |

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### Detail Information

| #   | Field                 | Description   |
|-----|-----------------------|---|
| 12. | Capped PPG/HOSP/PHONE | If a claim was denied on the explanation of check (EOC), then the name of the PPG or hospital where the claim was sent for processing would be listed here with the most current phone number that Health Net has on file |
| 13. | Member ID             | Health Net's member identification number   |
| 14. | MBR Last Name         | The last name of the member   |
| 15. | MBR First Name        | The first name of the member  |
| 16. | Claim Number          | Health Net's 11-digit Document Control Number (DCN)   |
| 17  | Beg DOS               | The starting date of facility/ professional services  |
| 18  | End DOS               | The ending date of facility/ professional services  |
| 19. | PROC                  | The billed procedure code on the UB-04 or CMS-1500 claim (if services billed are revenue, this field is blank)  |
| 20. | DIAG                  | A three to seven character code based on the ICD-10 coding system, indicating the condition for which services on this claim were rendered  |

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| #   | Field      | Description   |
|-----|------------|---|
| 21. | EOC        | <p>A three-digit code appears on the provider's EOC explaining the action taken on this claim line. If a claim is coded with EOC 300 or 308, then the claim was denied to responsible capitated PPG or capitated facility for services rendered</p> <p>300 = Service capitated to member's PPG, claim sent to PPG</p> <p>308 = Service capitated to facility, claim sent for processing</p> |
| 22. | Billed Amt | The amount billed for a claim line  |

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

## Plan-Risk or Shared-Risk Claims

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

The following information must be included on every claim:

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

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

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

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

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

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

For more information, select any subject below:

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

## 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

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

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

## Eligibility Guarantee

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

For more information, select any subject below:

[Eligibility Guarantee Under COBRA](#)

## Eligibility Guarantee Under COBRA

Provider Type: Participating Physician Groups (PPG) | Hospitals

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

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

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

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

## COBRA Eligibility Determination - Not applicable to IFP

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

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

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If the member answers "yes":

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

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

## Eligibility Reports (only applicable to PPGs)

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

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

## Filing a COBRA Eligibility Guarantee Claim

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

## Members Not Entitled to COBRA Continuation

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

Members Requesting COBRA Information

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

## Fee-For-Service Billing and Submission

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

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

Select any subject below:

- [Electronic claims Submission](#)
- [Electronic claims Submission \(IFP\)](#)

## Electronic Claims Submission

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

For electronic claim submissions check the current member identification (ID) for the correct payer ID.

The benefits of electronic claim submission include:

- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.
- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

## Reports

For successful electronic data exchange (EDI) claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from the EDI vendor
- Confirmation/rejection reports from the EDI clearinghouse
- Confirmation/rejection reports from Health Net

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed/ viewed. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

For questions regarding electronic claims submission, contact the [Health Net EDI Department](#).

## Electronic Claims Submission IFP

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

For electronic claims submissions that apply to providers serving individual family plan (IFP) members, check the current member identification (ID) card for the correct payer ID.

The benefits of electronic claim submission include:

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- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.
- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

For questions about electronic claims or electronic remittance and explanation of payment for IFP member claims, email [EDIBA@centene.com](mailto:EDIBA@centene.com) or contact the [Health Net/Centene EDI Department](#).

## PPO Billing

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

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

Workers' compensation does not apply to individual family plans, such as EnhancedCare PPO or Individual Family Plan PPO.

If the member has an approved workers' compensation claim, the provider should obtain the workers' compensation insurance information from the member and/or the member's employer and bill the appropriate workers' compensation carrier directly for payment. In the event that Health Net pays a claim on behalf of its member, and subsequently discovers that the member has an approved workers' compensation case, Health Net instructs the provider to bill the applicable workers' compensation carrier and refund Health Net.

In the event that the member's workers' compensation claim is contested by the employer, Health Net may file a lien against the member's workers' compensation benefits. In the interim, Health Net pays the covered charges. When the case is settled, Health Net may recover charges for services from the member's workers' compensation settlement. If the settlement agreement results in payment to the provider, the provider is responsible for refunding Health Net's payment.

## Premium Payment Grace Period for Beneficiary Qualifying for APTC

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

Beneficiaries who qualify for the advanced premium tax credit (APTC) subsidy used to purchase a health benefit plan through the Covered California marketplace are allowed a premium payment grace period for delinquent premiums for three months before Health Net can disenroll the beneficiary. This grace period does not apply to marketplace beneficiaries who do not receive the APTC.

## Overview

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During the first month of premium delinquency, Health Net reimburses providers for covered services delivered to APTC beneficiaries, in accordance with standard benefit guidelines.

Starting with the first day of the second month of delinquency, the beneficiary's eligibility reflects a suspended coverage status when a provider verifies eligibility prior to rendering services.

The suspended coverage status remains throughout the second and third month of the grace period unless the beneficiary pays his or her outstanding premium in full. If the premium remains unpaid at the end of the grace period, the beneficiary is disenrolled from the Health Net plan effective the last day of the first month of the grace period.

## Claims Submission and Processing

If a provider delivers covered services during the first month of the grace period, Health Net processes the claim for payment in accordance with standard benefit guidelines. Prior to delivering care to a beneficiary, providers must verify the beneficiary's active eligibility status with Health Net. Starting with the second month of the grace period, if a provider delivers covered services to a beneficiary in suspended coverage status, Health Net contests the claims, as the beneficiary is not considered eligible. If the beneficiary pays delinquent premiums in full before the end of the grace period, Health Net processes these claims for payment. If the beneficiary does not pay delinquent premiums in full by the end of the grace period, Health Net denies these claims due to the beneficiary's ineligibility.

## Provider Notification

Health Net participating providers who have submitted claims in the two months prior to a beneficiary entering the second month of the grace period receive notification from Health Net of the beneficiary's transition to suspended coverage status. Additionally, for beneficiaries enrolled in a Ambette HMO, the beneficiary's primary care physician (PCP) and affiliated participating physician group (PPG), if any, receive a notification of suspended coverage status. Health Net mails providers a notice of contested claims upon initial contesting, as well as 30 days after, if the beneficiary is still in the grace period. Upon the beneficiary's payment of all outstanding premiums that results in his or her reinstatement of eligibility, or upon expiration of the grace period that results in the beneficiary's termination as of the last day of the first month of the grace period, Health Net processes these claims accordingly.

Providers are under no contractual obligation to provide services during the suspended coverage period and may require patients to pay for care directly or agree to a payment guarantee in the event they eventually disenroll at the end of the grace period.

## Professional Claim Editing

### Physicians

Health Net has a contractual relationship with Cotiviti to provide a technology solution for professional claim edit policy management. Using Cotiviti's services, Health Net has the ability to apply advanced contextual processing for application of Health Net edit logic. Health Net also uses another editing vendor, Verscend, to perform a secondary review after Cotiviti.

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The process is as follows:

- Health Net customizes and controls the selection of all edit policy.
- Claims are transferred through various interfaces to Cotiviti every night.
- Cotiviti reviews each claim in the file and renders coding recommendations based on Health Net's edit policy.
- After Cotiviti review, if there are any unedited lines remaining, they are sent to Verscend for a secondary review.
- Once all reviews are complete edit recommendations from the vendors are then applied to the claims.

Cotiviti and Verscend also provide management support services, including edit policy advisory services. The vendor's Medical Policy teams conduct ongoing research into payment policy sources, including, but not limited to, the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and other specialty academies, to provide Health Net with the necessary information to make informed decisions when establishing edit policy.

## Refunds

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

This section contains general information on refunds, including verpayment procedures and third-party liability recovery.

Select any subject below:

- [Overpayment Procedures](#)

## Overpayment Procedures

Provider Type: Physicians | Hospitals

If a provider is aware of receiving an overpayment made by Health Net, including, but not limited to, overpayments caused by incorrect or duplicate payments by Health Net, errors on or changes to the provider billing or payment by another payer who is responsible for primary payment, the provider must promptly refund the overpayment amount to the Health Net Overpayment Recovery Department with a copy of the applicable Remittance Advice (RA) and a cover letter indicating why the amount is being returned. If the RA is not available, provide member name, date of service, payment amount, Health Net member identification (ID) number, provider tax ID number, and provider ID number.

When Health Net determines that an overpayment has occurred, Health Net notifies the provider of services in writing within 365 days of the date of payment on the overpaid claim through a separate notice that includes the following information:

- Member name
- Claim ID number
- Clear explanation of why Health Net believes the claim was overpaid
- The amount of overpayment, including interest and penalties

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The 365-day time period does not apply to overpayments caused in whole or in part by fraud or misrepresentation on the part of the provider.

The provider of service has 30 business days to submit a written dispute to Health Net if the provider does not believe an overpayment has occurred. In this case, Health Net treats the claim overpayment issue as a provider dispute.

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 that accompanied the overpayment or the refund request letter to expedite Health Net's adjustment of the provider's account. If neither of these documents are available, the following information must be provided: member name, date of service, payment amount, Health Net member ID number, vendor name and number, provider tax ID number, provider number, vendor number and reason for the overpayment refund. If the RA is not available, it may take longer for Health Net to process the overpayment refund.
- Send the overpayment refund and applicable details to the [Health Net Overpayment Recovery Department](#). If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net, such as 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 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:

- [PPO Coinsurance and Copayments](#)

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# PPO Coinsurance and Copayments

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

The coinsurance amount due from the member is based on the contract rate or the provider's usual charge, whichever is less. Health Net's payment plus the member's copayment or coinsurance amount equals 100 percent of the payment due to the provider pursuant to the participating provider's Provider Participation Agreement (PPA).

## Direct Payment to Providers

PPO participating providers submit claims to Health Net directly rather than billing the member. Health Net reimburses the provider directly, resulting in faster payment.

If the provider bills the member first rather than Health Net, the provider's agreement with Health Net may be subject to termination. If the provider does not comply with the claims submission guidelines and bills the member, Health Net reimburses the member (minus any scheduled copayments or coinsurance).

## Explanation of Benefits

An explanation of benefit (EOB) detailing the provider reimbursement payment is mailed to both the provider and member on payment of the claim. The EOB displays amounts that were paid under the PPO benefit level, as well as member copayments and coinsurance amounts. It identifies charges which are over the contract rates for which the member is not to be billed.

If coverage is denied, the denial reason and appeal process is included in the member EOB and the provider remittance advice (RA).

## Reimbursement Amount

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

The provider may not charge the member for medical services that Health Net has denied as not covered under the member's benefit plan, unless the member has agreed in writing to be responsible for payment of such charges.

## PPO Explanation of Benefits

An explanation of benefit (EOB) detailing the provider reimbursement payment is mailed to both the provider and member on payment of the claim. The EOB displays amounts that were paid under the PPO benefit level,

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as well as member copayments and coinsurance amounts. It identifies charges over the contract rates for which the member is not to be billed.

## Pharmacist Services

Provider Type: Participating Physician Groups (PPG)

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

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

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

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

## Salud con Health Net

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

Health Net is responsible for processing all claims under Salud con Health Net EPO and PPO plans as follows:

- Medico Hispano/Clinica Medica General providers submit claims to their IPA per established process. The IPA batches the claims and forwards them directly to Health Net for processing
- Lakewood Regional Hospital (Tenet facility) submits claims directly to Health Net for processing
- Sistemas medicos Nacionales S.A. de C.V (SIMNSA) providers send their claims to SIMNSA, which forwards the claims to Health Net
- Salud con Health Net PPO providers in California send their claims directly to [Health Net PPO Claims](#)
- Out-of-network providers in Mexico send their claims to SIMNSA, which generates any needed denial letters
- Out-of-network providers in California send their claims to [Health Net PPO Claims](#) or [Health Net EPO Claims](#) for payment as applicable

For more information, select any subject below:

- [Claims Process](#)



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## Claims Process PPO Plus

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

Health Net is responsible for processing all claims under the Salud con Health Net PPO Plus plan as follows:

- Health Net PPO providers in California send their claims directly to [Health Net PPO claims](#)
- Out-of-network providers in California send their claims to Health Net
- Sistemas medicos Nacionales S.A. de C.V (SIMNSA) providers send their claims to SIMNSA, which forwards the claims to Health Net
- Out-of-network providers in Mexico send their claims to SIMNSA, which generates any needed denial letters and forwards applicable claims to Health Net for payment

## Schedule of Benefits and Summary of Benefits

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

Health Net's Schedule of Benefits is a summary of services that may be covered under the plan. Benefits listed on the Schedule of Benefits are subject to change. The Schedule of Benefits and Summary of Benefits is updated weekly with new plan, benefit and copayment changes as applicable and can be access on the [Health Net provider portal](#).

## Timely Filing Criteria

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

If a claim is denied for timely filing, but the provider can demonstrate good cause for the delay, Health Net accepts and adjudicates the claim as if it were submitted in a timely manner. The Health Net Provider Appeals Unit considers and makes the determination of whether or not there is a good cause for the delay. Health Net has standardized guidelines for showing good cause for delay and goodwill adjustments.

## Good Cause for Delay Guidelines

Good cause for delay applies for providers who received misinformation from members or Health Net that caused timely filing claim denials and can demonstrate good cause for claim submission delays within the guidelines below:

- The delay was not reasonably in the provider's sole ability to control. For example: The provider received misinformation from the member and the provider is submitting one of the following:

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- Patient information form and/or member identification (ID) card presented by the Health Net member.
- Explanation of benefit (EOB) from incorrect carrier and/or participating physician group (PPG).
- The provider has followed Health Net instructions.
- Circumstances existed that the provider could not foresee or prevent.
- The length of the delay was such that it was unreasonably difficult or impossible for the provider, in the normal course of business, to file the claim in a timely manner.
- The delay was not the result of the provider's negligent or willful action or inaction.

## Other Adjustments Guidelines

For providers who can show proof of claim timely filing, Health Net gives consideration to other provider claim adjustments. The other adjustment policy guidelines are as follows:

- The provider submits proof in the form of one of the following:
  - Electronic data interchange (EDI) confirmation that Health Net received and accepted the claim.
  - Delivery confirmation evidence (for example, registered receipt or certified mail receipt to a Health Net address).
  - Screen print from accounting software to show the date the claim was submitted.

## When Medicare is a Secondary Payer

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

Health Net works to coordinate member benefits with identified third-party payers, which may include private and government insurance plans. Medicare is generally the primary payer for a member unless the member's current situation dictates his or her private insurance plan is primary to Medicare, such as when the member is actively employed and covered by an employer group benefit plan. In such cases, and when Medicare has previously paid for services as the primary carrier, Medicare issues a Medicare secondary payer (MSP) recovery demand letter. The demand letter includes the participating provider liability claims and claims details and requests a refund from the employer directly and Health Net indirectly as the employer's designated health plan.

If Health Net determines that the MSP recovery demand contains provider liability claims, Health Net sends the provider's MSP contact a demand letter with detailed instructions for responding to the demand, a spreadsheet listing the claims, and a copy of all claims that require provider intervention. (Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Manuals 100-05 Chapters 1-4)

Providers who have questions, contact the [Health Net Provider Services Center](#) or the [Medicare Provider Services Center](#).



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# 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

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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

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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:

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- 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](http://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

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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.



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## 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.



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## 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.

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## 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.

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## 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

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## 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.

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- 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)<br><br>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

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

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

## Compliance and Regulations

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

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

Select any subject below:

- [Mandatory Data Sharing Agreement](#)
- [Reproductive Privacy Act](#)
- [Provider Offshore Subcontracting Attestation](#)
- [Communicable Diseases Reporting](#)
- [Federal Lobbying Restrictions](#)
- [Health Net Affiliates](#)
- [Material Change Notification](#)
- [Nondiscrimination](#)

## Mandatory Data Sharing Agreement

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

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

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

Participating entities that must sign a DSA include:

- General acute care hospitals.
- Physician organizations and medical groups.

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- 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:<sup>1</sup>

- **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.

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- **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.

<sup>1</sup>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](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB352) or [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=202320240SB345](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB345).

# Provider Offshore Subcontracting Attestation

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

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

An example of an offshore subcontracting relationship is a physician, laboratory, medical group, or hospital contracting with an entity to process claims, and that entity uses resources that are not located in the United States to process the provider's claims. The provider is responsible to have processes in place that protect members' PHI.

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

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

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

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

## Communicable Diseases Reporting

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

To protect the public from the spread of infectious, contagious and communicable diseases, every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, are required by law to notify the local health department (LHD). A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

The term health care provider includes physicians and surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, and dentists.

## Notification

Providers must report cases of communicable diseases using the [Confidential Morbidity Report \(PDF\)](#) . They must send a completed copy of the report to the Communicable Disease Control division of the County Health Department. The time frame for reporting suspected cases of communicable diseases varies according to disease and ranges from immediate reporting by telephone or fax to seven days by mail.

The notification must include the following, if known:

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- 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

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Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing site, other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

## HIV Reporting Requirement for Providers

HIV is a reportable disease under California state law. Health care providers are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer within seven calendar days.

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

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

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

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

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

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

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

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

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

Most laboratories are also required to report confirmed tests to the local health office; however, this does not relieve the provider's reporting responsibility. Laboratories may not submit reports to the local health

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department for confirmed HIV tests for patients of an alternative testing sites other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

## Reporting Requirements for Hepatitis and Sexually Transmitted Infections

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

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

## Tuberculosis Reporting and Care Management

Tuberculosis (TB) reporting is done immediately by telephone or fax to expedite the process. The [Confidential Morbidity Report form \(PDF\)](#) should be used to notify the local health department's Communicable Disease Reporting Divisions. When reporting a case of TB, the health care provider must provide information on the diagnostic status of the case or suspected case; bacteriological, radiological and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons; and a list of the anti-tuberculosis medications administered to the member. In addition, a report must be made any time a person ceases treatment for TB, including when the member fails to keep an appointment, relocates without transferring care, or discontinues care. Further, the local health officer may require additional reports from the health care provider.

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

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

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

### Tuberculosis Care Management

When requested by the primary care physician (PCP) or local county health TB control officer, the Care Management Department provides assistance with coordination of the member's care. All cases referred to the Care Management Department are managed by gathering demographic and medical information. The care managers analyze the data, assess the member's needs, identify potential interventions, and follow the

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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.

## Federal Lobbying Restrictions

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

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

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

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

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

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

## Health Net Affiliates

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

Below is a listing of Health Net's affiliates. Health Net affiliates generally may opt to periodically access the *Provider Participation Agreement (PPA)* for covered services delivered by providers under those benefit programs in which providers participate.

- Arizona Complete Plan
- California Health and Wellness Plan
- Health Net Community Solutions, Inc.

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- Health Net Federal Services, LLC.
- Health Net Health Plan of Oregon, Inc.
- Health Net Insurance Services, Inc.
- Health Net Life Insurance Company
- Health Net of California, Inc.
- Managed Health Network, Inc.
- MHN Government Services, Inc.
- Network Providers LLC.
- Wellcare of California, Inc.

## Material Change Notification

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

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

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

## Nondiscrimination

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

The following nondiscrimination requirements apply.

## Employment

The plan and its participating providers must comply with the provisions of the Fair Employment and Housing Act (FEHA) (California Government Code, Section 12900 and following) and the regulations set forth in the California Code of Regulations, Title 2, Chapter 2, commencing with Section 7286.0 and following. The plan and its participating providers may not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. In addition, the plan and its participating providers ensure the following:

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- 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<sup>1, 2</sup>:

- 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.

<sup>1</sup> 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).

<sup>2</sup> 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.

## DMHC-Required Statement on Written Correspondence

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

The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. The DMHC requires that all written correspondence that could result in a member appeal or grievance, including claim denial letters, contain the following statement with the department's telephone numbers, the department's TDD line, the department's Internet address, and the plan's telephone number in 12-point boldface type in the following regular type statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number and a TDD line for the hearing and speech impaired. The DMHC website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov) has complaint forms, IMR application forms and instructions online.

The applicable Member Services Department telephone number for each line of business should also be included.

## Coordination of Benefits

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

This section contains general information for providers on coordination of benefits.

Select any subject below:

- [Overview](#)
- [COB Payment Calculations](#)
- [Disagreements with Other Insurers](#)
- [The Plan's Right to Pay Others](#)
- [When the Plan is the Primary Carrier](#)
- [When the Plan is the Secondary Carrier](#)

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

Coordination of benefits (COB) allows group health plans to eliminate the opportunity for a person to profit from an illness or injury as the result of duplicate group health plan coverage. Generally, one plan is determined to be primary, and that plan pays without regard to the other. The secondary plan then makes only a supplemental payment that results in a total payment of not more than the eligible expenses for the medical service provided.

If one plan is an individual plan, not a group plan, both plans pay as primary. The payments do not coordinate.

**Participating providers** are required to administer COB when such provisions are a requirement of the benefit plans. The participating provider should ask the member for possible coverage through any other group or individual insurance or HMO plan and enter the other health insurance information on the claim.

Contact the [Provider Services Department](#) with any information identifying COB coverage for a member.

## COB Payment Calculations

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

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

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

## Disagreements with Other Insurers

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

Not all insurers operate under the jurisdiction of the California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI). In some instances, insurers do not operate under any legal authority at all regarding coordination of benefits (COB). For this reason, hospitals may encounter insurers,

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administrators and others who would ordinarily be the primary carrier but refuse to pay. There is no practical recourse if they have different rules in their state or are a self-funded plan.

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

## 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.

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

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

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

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

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

## Copayments

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

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

Select any subject below:

- [Calculation of Coinsurance](#)
- [Out-of-Pocket Maximum](#)
- [Verify Copayments](#)

## Calculation of Coinsurance

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

Health Net's method of calculating member coinsurance for institutional charges is described below. This applies to plans that require a percentage coinsurance for inpatient or outpatient hospital services.

The coinsurance is based on the lesser of the allowable charges (billed charges minus disallowed charges) or the contract amount. For example, if a hospital submits a bill to Health Net for \$5,000 and Health Net has a contract with the hospital for \$4,000, the member (who has a 20 percent coinsurance) would then be responsible for 20 percent of the contract amount (\$4,000), which would be \$800 ( $\$4,000 \times 20\% = \$800$ ).



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## Out-of-Pocket Maximum

Provider Type: Physicians | Ancillary | Hospitals

When the member's total copayments, coinsurance and applicable deductible payments during any calendar or plan year, equal the out-of-pocket maximum (OOPM) listed in the [Schedule of Benefits](#) , no further deductibles (if applicable), copayments or coinsurance are required from the member for the remainder of that calendar or plan year.

Eligible copayments or coinsurance amounts paid by the member for services provided through the PPO plan apply towards the OOPM for out-of-network providers. In addition, the coinsurance paid for services provided through out-of-network providers applies towards the OOPM for PPO. Refer to the Schedule of Benefits for plan exceptions.

## Verify Copayments

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

Refer to the Schedule of Covered Services and Copayments in the subscriber's [Evidence of Coverage](#) (EOC) or [Certificate of Insurance](#) or the plan chart in the [Schedule of Benefits](#) to determine whether a copayment should be collected. For example, most plans have a copayment for emergency room or urgent care center treatment (when the copayment for emergency room or urgent care center treatment is less than the billed amount, the member is only responsible for the lesser amount).

Some plans have a copayment for hospitalization or for home health visits beginning with the 31<sup>st</sup> day of home health services. The copayments for emergency room, urgent care or hospitalization, inpatient or outpatient, must be collected by the institution providing the services. The copayments for home health services must be collected by the home health agency providing the services. These copayments contribute to the out-of-pocket maximum (OOPM).

For professional services, capitation or fee-for-service payments are supplemented by the Health Net member's copayments. Some of these payments accrue to the participating physician group (PPG) or provider and increase the total compensation received by the PPG or provider.

For benefit application purposes, Health Net's definition of a newborn is an infant from birth through its first 30 days. This is relevant only to a few plans that require office visit copayments for newborns.

## Credentialing

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

This section describes Health Net's provider credentialing process.

Select any subject below:

- [Application Process](#)

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- [State Requirement for Providing Behavioral Health Services](#)

## 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 appela 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

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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

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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, hospice and home infusion providers
- SNFs
- Free-standing and ASCs, including abortion clinics
- Dialysis/end-stage renal disease (ESRD) care providers
- Hospices
- Laboratories
- Office-based surgery suites
- Comprehensive outpatient rehabilitation facilities
- Physical therapy and speech pathology providers
- Portable X-ray suppliers
- Radiology/imaging centers
- Behavioral health facilities (inpatient, residential and ambulatory)
- Sleep study centers
- Urgent care centers
- Federally qualified health centers and rural health clinics
- Community-Based Adult Services (CBAS) centers

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- Other providers as deemed necessary

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 recredentialed 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 recredentialed 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 physicians (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

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recrediting within 36 months. Only licensed, qualified practitioners meeting and maintaining the standards for participation requirements are retained in the network.

Practitioners due for recrediting 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 recrediting 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](http://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.

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- 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.

## State Requirement for Providing Behavioral Health Services

Provider Type: Physicians | Participating Physician Groups (PPG)

All practitioners participating in the plan's network must comply with the following standards implemented on January 1, 2018, under Assembly Bill (AB) 1074 as it amended California Health and Safety Code section 1374.73 and California Insurance Code section 10144.51, when providing behavioral health treatment for pervasive developmental disorder or autism spectrum disorders (ASDs) for Health Net members.

Participating providers must ensure that qualified autism service professionals or paraprofessionals are supervised by a qualified autism service provider when providing behavioral health services and treatment for pervasive developmental disorder or ASDs. Health Net covers applied behavioral analysis (ABA) when medically necessary for Health Net members diagnosed with ASDs.

Qualified autism service providers must be certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, to design, supervise and provide treatment for pervasive developmental disorder or ASDs.

Rules of participation require that participating providers only assign Health Net members to qualified autism professionals and qualified autism paraprofessionals under a treatment plan prescribed by and supervised by a qualified autism service provider. These qualified autism professionals and qualified autism paraprofessionals must meet the following minimum qualifications:

A qualified autism service professional must meet the following criteria:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- Is supervised by a qualified autism service provider.
- Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.

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- Meets the education and experience qualifications as described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
- Has training and experience in providing services for pervasive developmental disorder or autism.
- Is employed by the qualified autism service provider or the participating physician group (PPG) that employs qualified autism service providers responsible for the autism treatment plan.

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

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services for a treatment plan developed and approved by the qualified autism service provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training and experience, as certified by a qualified autism service provider or the PPG that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

## 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:

- [Service Denial Templates](#)
- [Member Denial Letter Templates](#)
- [Required Elements for Member Notification Letters](#)
- [Required Elements for Provider Notification Letters](#)
- [Requirements for Notification of Utilization Management Decisions](#)

## Service Denial Templates

Provider Type: Participating Physician Groups (PPG) | Hospitals

Delegated participating physician groups (PPGs) and hospitals are required to notify a member in writing when a service is denied.

Service denial letters must specify:

- Letter date
- Member name

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- Provider name
- Specific service
- Date of service for concurrent review, if applicable
- Reason for the denial - Service denials for members must include a denial message; refer to the Industry Collaboration Effort (ICE) website at [www.iceforhealth.org/home.asp](http://www.iceforhealth.org/home.asp) to download the Commercial Pre-Service Denial Reasons Matrix Guidelines and other templates
- Appeals process and information
- Health Net department name, address, and telephone number for appeals
- The [Department of Managed Health Care \(DMHC\) Required Statement](#) for language and telephone number

Health Net encourages PPGs and hospitals to use the standardized ICE-approved HMO service denial letter templates. Refer to the [ICE](#) to view the following templates located under Approved ICE Documents:

- Commercial Service Denial Notice
- Commercial Delay Needed - Additional Information
- Notice of Non-Coverage - Termination of Services
- Acknowledgment of Receipt - Refusal to Sign
- Refusal to Transfer
- SNF Exhaustion of Benefits
- SNF Reinstatement Letter
- Carve-Out Situations

## Letters to Members

Communications regarding decisions to approve prior authorization requests must state the specific health care service approved.

Member notification letters indicating a denial, delay or modification of service must include:

- A clear and concise explanation of the reasons for the decision specific to medical necessity, benefit coverage or eligibility
- A description of the criteria or guidelines used
- The clinical reasons for any decisions regarding medical necessity
- Information on filing a grievance (or appeal)

PPG medical directors are encouraged to cite the language from the [Evidence of Coverage \(EOC\)](#) text models, including the specific service provision and the definition of medical necessity, in the denial of service notification to the member. Denials based on any determinant of medical necessity require further substantiation by medical literature, utilization management (UM) criteria set (such as Milliman and Robertson or Interqual), or other reputable evidenced-based criteria.

Providers are encouraged to use the approved ICE Commercial Service Denial Notice template when sending service denial notices to their members; refer to the [ICE website](#) to view the template located under Approved ICE Documents.

Refer to the DMHC Required Statement for additional requirements.



# Member Denial Letter Templates

Provider Type: Participating Physician Groups (PPG)

For utilization management (UM) and claims-delegated participating physician groups (PPGs), Health Net-specific Language Assistance Program (LAP) notices and member denial letter templates are available on the Industry and Collaborative Effort (ICE) website at [www.iceforhealth.org/library.asp](http://www.iceforhealth.org/library.asp) located under Approved ICE Documents.

## Required Elements for Member Notification Letters

Provider Type: Physicians | Participating Physician Groups (PPG)

Communications regarding decisions to approve requests must state the specific health care service approved.

Member notification letters indicating a denial, delay or modification of service must include:

- A clear and concise explanation of the reasons for the decision
- A description of the criteria or guidelines used
- The clinical reasons for the decisions regarding medical necessity
- Information on filing a grievance (or appeal)
- Information on contacting the California Department of Insurance (DOI)

## Required Elements for Provider Notification Letters

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

Communications regarding decisions to approve requests must state the specific health care service approved.

Provider notification letters indicating a denial, delay or modification of service must include:

- A clear and concise explanation of the reasons for the decision
- A description of the criteria or guidelines used
- The clinical reasons for the decisions regarding medical necessity
- Information on filing a grievance (or appeal)
- The name and direct telephone number (or extension) of the physician or otherwise qualified and licensed health care professional (such as a PharmD) responsible for the decision



In the case of a denial, the referring provider must be given an opportunity to discuss the denial with the physician who made the denial decision. Refer to the Industry Collaboration Effort (ICE) website at [www.iceforhealth.org/home.asp](http://www.iceforhealth.org/home.asp) to view the Denial File Fax Back template located under Approved ICE Documents. An expedient method for this purpose is to complete a Denial File Fax-Back Sample, including the name and telephone number of the physician who denied the service when faxing back the denial information.

## Requirements for Notification of Utilization Management Decisions

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

Health Net and its participating physician groups (PPGs) to which utilization management (UM) functions have been delegated are required to comply with timeliness standards for UM decisions and notifications. Health Net has adopted the timeliness standards approved by the Industry Collaboration Effort (ICE) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the ICE website at [www.iceforhealth.org/home.asp](http://www.iceforhealth.org/home.asp) to locate the Approved ICE Documents for the commercial and Medi-Cal ICE UM Timeliness Standards.

## Appeals, Grievances and Disputes

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

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

Select any subject below:

- [Member Appeals](#)
- [Provider Appeals and Dispute Resolution](#)
- [Grievances](#)
- [Peer-to-Peer Review Requests](#)

## Member Appeals

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

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

Select any subject below:

- [Member Appeals Overview](#)
- [Appeal Process](#)
- [Investigational or Experimental Treatment](#)

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# Member Appeals Overview

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

Health Net members are entitled to have their appeals or grievances addressed by Health Net and have a contractual right to claims arbitration for claims that are not resolved to their satisfaction. Health Net does not delegate appeals or grievances to [participating providers](#). If the participating provider becomes aware of a member appeal, the participating provider must fax the appeal to the [Health Net Member Appeals and Grievance Department](#) within one business day. Health Net's process includes peer-review-protected evaluations on the matters raised. A copy of the denial and relevant clinical information needs to be submitted with appeal requests. Health Net's grievance and appeal process includes peer-review-protected evaluation of the matters raised.

Grievances are a verbal or written statement, other than one that is an organization determination, expressing dissatisfaction regarding any aspect of an organization's or participating provider's operations, contractual issues, activities, or behavior. A grievance is generally further classified as either a quality-of-care or quality-of-service issue.

An appeal or request for reconsideration is a verbal or written request to change a previous service decision or adverse determination. The request can be from a member, a participating provider or a member representative and is categorized as either a pre-service, post-service, expedited, or external review.

The fact that a member submits an appeal or grievance to Health Net or the participating provider should not affect in any way the manner in which the member is treated by the participating provider. If Health Net discovers that any improper action has been taken against such a member by the participating provider, Health Net takes immediate steps to prevent such conduct in the future. These steps involve appropriate sanctions, including possible termination of the applicable Provider Participation Agreement (PPA).

Health Net requires that all participating providers provide all pertinent appeal or grievance documentation to the Health Net Member Appeals and Grievance Department by fax or mail within five calendar days of the participating providers' receipt of Health Net's request for information. Health Net expects the participating provider to review the matter promptly and work with Health Net on corrective actions needed as part of the overall quality improvement process. If the participating provider does not provide the necessary documentation, Health Net may be obligated to make a determination in the member's favor.

Refer to [Appeal](#), [Grievance](#), [Complaint](#), or [Inquiry](#) as applicable for additional information.

## Expedited

An expedited appeal is warranted if there is a time-sensitive situation where an adverse decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, defined as cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Expedited appeals includes pre-service appeals, a terminally ill appeal for a request for reconsideration of treatment, services or supplies deemed experimental as recommended by a [participating provider](#), or a life-threatening or seriously debilitating condition appeal.

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All expedited appeals that meet the above definition are processed within 72 hours from the time the request is received by the participating provider or Health Net.

## Financial Responsibility

Financial responsibility determinations are made consistent with the terms of the Provider Participation Agreement (PPA) and Health Net policy. If, during an appeal, Health Net or the independent medical review (IMR) overturns a denial, the responsible participating provider provides the service and pays the claim as stated in the PPA.

## Binding Arbitration Process

Sometimes disputes may arise between a member and Health Net regarding the construction, interpretation, performance, or breach of the member's [Evidence of Coverage \(EOC\)](#) or [Certificate of Insurance \(COI\)](#), or regarding other matters relating to or arising out of membership. Typically such disputes are handled and resolved through the Health Net appeal, grievance or independent medical review (IMR) processes. However, in the event that a dispute is not resolved, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties, such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition of membership, Health Net members agree to submit all disputes against Health Net, except those described later, to final and binding arbitration. Health Net agrees to arbitrate all of these disputes. This mutual agreement to arbitrate disputes means that both the member and Health Net use binding arbitration as the final means of resolving disputes that may arise between them, and forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law are forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate is enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrators selected by Health Net and the member. The Federal Arbitration Act, 9 U.S.C.1, et sea., governs arbitrations under this process. If the total amount of damages claimed is \$200,000 or less, Health Net and the member must, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who hears and decides the case and who cannot award more than \$200,000. In the event that the total amount of damages is more than \$200,000, Health Net and the member must, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless they mutually agree to one arbitrator), who hears and decides the case.

If Health Net and the member fail to reach an agreement during this time frame, then either may apply to a Court of Competent Jurisdiction for appointment of the arbitrators to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net's litigation administrator. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret the Health Net member's EOC or COI, but does not have any power to change, modify or refuse to enforce any of its terms, nor can the arbitrator have the authority to make any award that would not be available in a court of law. At the

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conclusion of the arbitration, the arbitrator issues a written opinion and award providing findings of fact and conclusions of law. The award is final and binding on Health Net and the member, except to the extent that state or federal law provides for judicial review of arbitration proceedings.

Health Net and the member share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each is also responsible for their own attorneys' fees. In cases of extreme hardship to a member, Health Net may assume all or a portion of a member's share of the fees and expenses of the arbitration. Upon written notice by the member requesting a hardship application, Health Net forwards the request for hardship to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the litigation administrator.

Members enrolled in an employer-sponsored health plan that is subject to ERISA, 29 U.S.C. 1001 et seq. are not required to submit disputes about certain adverse benefit determinations to binding arbitration. However, the member and Health Net may voluntarily agree to resolve adverse benefit determinations through the arbitration process.

## Appeal Process

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

A [participating provider](#) has five calendar days from receipt of a request for information from Health Net to submit to Health Net the case file information requested for a member appeal. Case file information includes medical records, the rationale for denial and an alternative treatment plan. Participating providers must follow Health Net's provider information request process when submitting pertinent case file documentation to Health Net.

Health Net is responsible for reviewing the case file, requesting any additional information needed from the participating provider, and upholding or overturning the denial. In addition, Health Net is responsible for informing members of their right to appeal to the [Department of Insurance \(DOI\)](#). This includes sending members an application form and addressed envelope so they can request an independent medical review (IMR) through the DOI for member appeals that have been denied for lack of medical necessity or for investigational or experimental treatment. The IMR organization reviews the case, prepares a written decision, including its rationale, and submits the decision to the DOI, member and Health Net. Health Net accepts the IMR recommendation, then sends the IMR decision and rationale to the participating provider and notifies the member in writing whether the denial was upheld or overturned. If the denial is upheld, the member has the right to request arbitration.

## Investigational or Experimental Treatment

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

A member with a life-threatening or seriously debilitating condition who disagrees with a Health Net denial of coverage for a service, medication, device, or procedure because it is investigational or experimental may request an appeal review. If the denial is sustained, the member can request an independent medical review (IMR) from the [Department of Insurance \(DOI\)](#).

Participating providers are to forward immediately to Health Net any requests they receive for investigational or experimental treatment for a Health Net member. These requests cannot be reviewed by the participating provider.

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Services, medications, devices, or procedures that have not been accepted under standard medical practice for treatment of a condition, symptom, illness, or injury are excluded from coverage by Health Net. If a question arises as to whether a service, medication, device, or procedure is investigational or experimental, the Health Net Medical Management Department reviews the information and makes a coverage determination.

## Provider Appeals and Dispute Resolution

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

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

Select any subject below:

- [Overview](#)
- [Acknowledgement and Resolution](#)
- [Dispute Submission](#)
- [Inquiry Submission](#)

## Overview

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

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

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim
- Challenge a request by Health Net for reimbursement for an overpayment of a claim
- Seek resolution of a billing determination or other contractual dispute with Health Net
- Appeal a written determination when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the written determination

Health Net does not charge providers of service who submit disputes to the [Health Net Provider Dispute - Commercial Appeals Unit \(PDF\)](#), the [Health Net Provider Appeals Unit - IFP](#) for processing provider disputes and does not discriminate or retaliate against a participating provider who uses the provider dispute process.

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

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

- Inquire about the status of a claim or obtain payment calculation clarification

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- Resubmit contested claims with the missing information requested by Health Net
- Submit a corrected claim (additional charges previously not submitted)
- Clarify member responsibility

To check the status of an appeal or dispute, contact the applicable [Health Net Provider Services Center](#).

## Acknowledgement and Resolution

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

Health Net acknowledges receipt of each provider dispute, in writing and within 15 business days of receipt. If the provider dispute submission does not include all pertinent details of the dispute, it is returned to the provider with a request detailing the additional information required to resolve the issue. The amended dispute must be submitted with the missing information within 30 business days from the date of receipt of the request for additional information.

Providers are not asked to resubmit claim information or supporting documentation that was previously submitted to Health Net as part of the claims adjudication process, unless Health Net returned the information to the provider.

Health Net resolves each provider dispute within 45 business days following receipt and sends the provider a written determination stating the reasons for the determination.

If the provider dispute involving a claim for a provider's services is resolved in favor of the provider, Health Net pays any outstanding money due, including any required interest or penalties, within five business days of the decision. Accrual of the interest and penalties, if any, commences on the day following the date by which the claim or dispute should have been processed.

Participating providers who contract directly with Health Net and disagree with Health Net's determination may refer to their Provider Participation Agreement (PPA) for other available resolution mechanisms.

## Dispute Submission

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

Health Net accepts disputes, including appeals, from [participating providers](#) if they are submitted within 365 days of receipt of Health Net's decision (for example, denial or adjustment), except as described below. If the participating provider does not receive a decision from Health Net, the dispute must be submitted within 365 days after the deadline for contesting or denying the claim has expired. If the participating provider's Provider Participation Agreement (PPA) provides for a dispute-filing deadline that is greater than 365 calendar days, this longer time frame continues to apply until the contract is amended.

When submitting a provider dispute, a provider should use the Provider Dispute Resolution Request form - [Provider Dispute Resolution Request form - Health Net \(PDF\)](#), [Provider Dispute Resolution Request form - Community Health Plan of Imperial Valley \(PDF\)](#) or [Provider Dispute Resolution Request form - CalViva Health \(PDF\)](#). If the dispute is for multiple, substantially similar claims, the Provider Dispute Resolution Request spreadsheet (page two of the request form above and up to 12 claims) or the Claims Project Submission Universal Template spreadsheet (used for more than 12 claims) should be submitted with the Provider Dispute Resolution Request form. The Claims Project Submission Universal Template spreadsheet should be

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requested from your Provider Network Management contact. Provider Network Management will email you a copy of the spreadsheet template to complete and submit along with the Provider Dispute Resolution Form.

The provider dispute must include:

- The provider's name; identification (ID) number; contact information, including phone number; and the original claim number.
- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include: a clear identification of the disputed item; the date of service; and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is not about a claim, the provider must include a clear explanation of the reason for the dispute, including, if applicable, relevant references to the PPA.

A provider dispute that is submitted on behalf of a member is considered a member appeal and is processed through the member appeal process. Providers may submit member appeals using the Provider Dispute Resolution Request form below.

- [Health Net Member Appeals and Grievances Department](#) (HMO, HSP, PPO and EPO)
- [Medi-Cal Member Appeals and Grievances Department](#) (Health Net Medi-Cal, Community Health Plan of Imperial Valley or CalViva Health).

Submit disputes to the [Health Net Provider Appeals Unit](#) (HMO, HSP, PPO and EPO) or the [Medi-Cal Provider Appeals Unit](#) (Health Net Medi-Cal, Community Health Plan of Imperial Valley or CalViva Health).

Providers who participate under a capitated agreement with a participating physician group (PPG) must submit disputes to the PPG that processed the claim.

## Inquiry Submission

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

For routine claim follow-up, contact the appropriate Provider Services Center.

Provider dispute requests are submitted to the [Health Net Provider Dispute and Inquiry Resolution Unit](#).

## Grievances

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

Members may submit grievances orally or in writing to the [Member Appeals and Grievance Department](#).

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

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

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

## DMHC Notices of Translation Assistance, Forms and Applications

### DMHC Notices of Translation Assistance

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

### Translated DMHC Complaint (Grievance) Forms

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

### Translated DMHC IMR Applications

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

## Ancillary Providers and Notice of Language Assistance

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

## 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.

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

## COBRA Continuation

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

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## 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.

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## 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.

## Extension of Benefits

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a totally disabled member loses coverage because the group agreement between Health Net and the employer group has terminated, California laws require group health plans (HMOs) and group policy underwriters (PPOs) to extend coverage, but only for services directly related to the disabling condition. Application for the extension of benefits must be submitted by the member and certification of the disabling condition completed within 90 days following the date the group agreement terminated. The request for extension of benefits must include written certification by the member's participating physician group (PPG) that the member is totally disabled.

If benefits are extended because of total disability, the member must provide Health Net with proof of total disability at least once every 90 days during the extension, before the end of the 90-day period.

The extension of benefits ends on the earliest of any of the following dates:

- On the date the member is no longer totally disabled
- On the date the member becomes covered by a replacement health policy or plan obtained by the group and this coverage has no limitation for the disabling condition
- On the date that available benefits are exhausted
- On the last day of the 12-month period following the date the extension began

Refer to the member's [Evidence of Coverage \(EOC\)](#) or [Certificate of Insurance \(COI\)](#) for additional information, or contact the [Health Net Provider Services Center](#).





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

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

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

To verify eligibility providers can utilize the [Health Net provider portal](#).

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

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

- Members receiving federal APTCs and/or California premium subsidies will have a federally mandated grace period of three months in which to make payment for their portion of the premium.
  - Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
  - All members associated with the subscriber will inherit the enrollment status of the subscriber.
  - When providers are verifying eligibility through the secure provider portal during the first month of nonpayment of premium, the provider will receive a message that the member is active but delinquent due to nonpayment of premium. However, claims may be submitted and Health Net will pay for covered services rendered during the first month of the grace period.
  - During months two and three of the grace period, the member's eligibility status is suspended, and claims will be pended. The EX code on the explanation of payment will state: "LZ - Pend: Non-Payment of Premium."
  - Coverage will remain in force during the grace period.
  - If payment of all premiums due is not received from the member by the end of the three-month grace period, the member's policy will automatically terminate to the last day of the first month of the grace period.
  - The member will be financially responsible for the cost of covered services received during the second and third months of the grace period, as well as any unpaid premium.
  - In no event shall coverage extend beyond the date the member policy terminates.

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

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

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

## Verifying Eligibility for IFP Members

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

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

If the member's information is not found online, contact the applicable [Health Net Provider Services Center](#).

# Steps to Determine Eligibility

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

This section contains information on verifying and determining member eligibility.

Select any subject below:

- [Eligibility Verification Methods](#)

# 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:

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- 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. Does not apply to PPO.
- Online: Download the [Save Time Navigating the Provider Portal \(PDF\)](#) booklet for step-by-step instructions.
- The [interactive voice response \(IVR\)](#) system for employer group EPO, HMO, HSP and PPO members to obtain information on member eligibility, copayment and claims status.
- Refer to the [IVRs](#) available for Covered California and Individual Family Plan (IFP) members to obtain information on member eligibility, copayments and claims status.
- Eligibility verification via the provider's clearinghouse. Health Net is a Phase I- and Phase II-certified entity with the Council for Affordable and Quality Healthcare (CAQH) Committee on Operating Rules (CORE) for eligibility responses. Providers must contact their vendor/clearinghouse to submit transactions via this method using an EDI transaction or clearinghouse product.

## Grace Period - Suspended Eligibility Status

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

## Monthly Eligibility Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

## Activity Analysis Report

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

## Use Eligibility Report to Verify Member Information

Health Net provides each capitated participating physician group (PPG) and capitated hospital with a monthly Eligibility Report listing eligible members enrolled with the PPG and capitated to the hospital per applicable

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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.

## Emergency Services

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

This section contains general member benefit information on emergency care services.

Select any subject below:

- [Overview](#)

## Overview

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

Emergency care is covered for acute illness, new injuries or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of severe mental illness and serious emotional disturbances of a child), and believes that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger)
- His or her bodily functions, organs or parts would become seriously impaired
- His or her bodily organs or parts would seriously dysfunction

Emergency care also includes:

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- Treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur:
  - There is inadequate time to effectively transfer safely to another hospital prior to delivery
  - A transfer poses a threat to the health and safety of the covered person or unborn child
- Ambulance and ambulance transport services provided through the 911 emergency response system, if the request was made for emergency care
- Additional screening, examination and evaluation by a physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment are necessary to relieve or eliminate such condition, within the capability of the facility
- Treatment of shortness of breath and/or bleeding

Health Net makes final determinations about emergency care.

## Encounters

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

This section contains general information about encounter data submission.

Select any subject below:

- [Lien Recoveries](#)

## 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.



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## Enrollment

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

This section contains general information and procedures regarding member enrollment.

Select any subject below:

- [Dependent Documentation Provided to Non-Subscriber](#)
- [Subscriber and Member Identification Numbers](#)
- [Use of Social Security Numbers](#)
- [Late Enrollment Rules Waived](#)

## Dependent Documentation Provided to Non-Subscriber

Provider Type: Physicians | Participating Physician Groups (PPG)

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

## Subscriber and Member Identification Numbers

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

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

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

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

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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.

## Late Enrollment Rules Waived

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

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

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

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

## 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

Health Net sends new identification (ID) cards automatically sent when:

- A new member enrolls
- A member changes their name
- A dependent is added or deleted from the policy and the group number changes
- 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 \(Elect Open Access\) \(PDF\)](#)
- [Identification card \(Ambetter PPO\) \(PDF\)](#)
- [Identification card \(PPO\) \(PDF\)](#)
- [Identification card \(Select POS\) \(PDF\)](#)

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





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# Medical Records

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

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

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

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

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

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

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

## Provision of Medical Records

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

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

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

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

### Access to Records and Audits by Health Plan

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

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

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

### EMR Access

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

## Written Protocols

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

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included
- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)

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- Formal system for the availability and retrieval of medical records - Policy and procedure must allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - Policy and procedure must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with state laws and regulations (for providers who see commercial health plan patients)
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicare patients)
- Preventive care guidelines for pediatric and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of member information

For more information, select any subject below:

- [Confidentiality of Medical Records](#)
- [Medical Record Documentation](#)
- [Medical Record Forms and Aids](#)

## Confidentiality of Medical Records

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

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, claims and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. Written authorization from the member or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the health plan.

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

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

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PHI is considered confidential and encompasses any individual health information, including demographic information collected from a member, which is created or received by Health Net and relates to the past, present or future physical, mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member or there is a reasonable basis to believe the information may be used to identify the member. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written member authorization.

## Confidentiality of Medical Information

Sensitive services are defined as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924-6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

Assembly Bill 1184 (2021), amends the Confidentiality of Medical Information Act to require health care plans to take additional steps to protect the confidentiality of a subscriber's or enrollee's medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

These steps include:

- A protected individual (member) is not required to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care.
- Not disclose a member's medical information related to sensitive health care services to the primary subscriber or other enrollees, unless the member's authorization is present.
- Notify the subscriber and enrollees that they may request confidential communications and how to make the request. This information must be provided to "enrollees" at initial enrollment and annually.
- Respond to confidential communications requests within:
  - 7 calendar days of receipt via electronic or phone request or
  - 14 calendar days of receipt by first-class mail
- Communications (written, verbal or electronic) regarding a member's receipt of sensitive services should be directed to the member's designated mailing address, email address, or phone number. For protected individuals who may not have designated an alternative mailing address, the provider and/or Plan is required to send the communications to the address or phone number on file in the name of the protected individual.
- Confidential communication includes:
  - Bills and attempts to collect payment.
  - A notice of adverse benefits determinations.
  - An explanation of benefits notice.
  - A plan's request for additional information regarding a claim.
  - A notice of a contested claim.
  - The name and address of a provider, description of services provided, and other information related to a visit.
  - Any written, oral, or electronic communication from a plan that contains protected health information.

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## Agencies Must Be Authorized To Receive Medical Records

The relationship and communication between a [participating provider](#) and member is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and protected health information (PHI), whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

## Requirements for a Valid Authorization for Release of Information

Providers must obtain signed authorization from the member to use or disclose the member's [medical information](#). You also need to give instructions to members on how to access additional copies or digital versions of the signed authorization. The signed authorization must:

- Be written in plain language and no smaller than 14-point font.
- Be dated and signed with an electronic or handwritten signature by the member or person authorized to act on behalf of member.
- Specify the type of individuals authorized to disclose information about the member.
- Specify the nature of the information authorized to be disclosed.
- State the name or functions of the persons or entities authorized to receive the information.
- Specify the purposes for which the information is collected.
- Specify the length of time the authorization shall remain valid.
- State an expiration date or event. The expiration date for a valid signature is up to one year unless the person signing the authorization requests a specific date beyond a year, or the authorization is related to an approved clinical trial<sup>1</sup> after which the provider, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

## Real Time Data Exchange of Health Information

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

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

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## Exceptions

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

- Physician practices of fewer than 25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.
- Abortion and abortion-related services.

## Basic Principles

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

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

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

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

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

- Written or oral communication whereby the communicator receives no compensation from a third party
- Communications made to a current member solely for the purpose of describing a provider's participation in an existing health care provider network or health plan network to which the member subscribes
- Communications made to a current member solely for the purpose of describing products, services, payment, or benefits for the health plan to which the member subscribes
- Communication to describe a plan benefit or an enhancement or replacement to a benefit
- Communications describing the availability of more cost-effective pharmaceuticals
- Compensation communications tailored to a specific individual that educate or advise them about disease management or life-threatening, chronic or seriously debilitating conditions if:

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- The member receiving the communication is notified in writing that the provider, contractor or health plan has been compensated, and identifies the source of the compensation
- The communication must include information on how the member can opt out of receiving further communications by calling a toll-free number and must be written in 14 point font or larger. No communication can be made to a member who has opted out after 30 days from the date of the request
- Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release PHI regarding sensitive conditions, Health Net and participating providers must obtain written authorization from the member (or authorized representative) stating that information specific to the sensitive condition may be disclosed.

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

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

## Procedure

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

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

Release of medical information guidelines must address:

- Requests for PHI via the telephone
- Demands made by subpoena duces tecum
- Timely transfer of medical records to ensure continuity of care when a Health Net member chooses a new primary care physician (PCP)
- Availability and accessibility of member medical records to Health Net and to state and federal authorities or their delegates involved in assessing quality of care or investigating enrollee grievances or other complaints
- Availability and accessibility of member medical records to the member in a timely manner in accordance with industry standards and best practices
- Requirements for medical record information between providers of care:

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- A physician or licensed behavioral health care provider making a member referral must transmit necessary medical record information to the provider receiving the member referral
- A physician or licensed behavioral health care provider furnishing a referral service provides appropriate information back to the referring provider
- A physician or licensed behavioral health care provider requesting information from another treating provider as necessary to provide care. Treating physicians or licensed behavioral health care providers may include those from any organization with which the member may subsequently enroll

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

- A specific and meaningful description of the information to be used or disclosed
- The name of the person or entity authorized to make the requested use or disclosure
- The name of a person or entity to which the use or disclosure may be made
- A description of each purpose or use for the information. If the individual requests the authorization for their own purposes, the description here may read simply "at the request of the individual"
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- The signature of the individual and the date
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation
- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization, unless a valid exception applies (such as, pre-enrollment underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule

## Medical Record Documentation

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

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

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

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For more information, select any subject below:

- [Advance Directives](#)
- [Medical Record Documentation Standards](#)
- [Medical Record Performance Measurements](#)

## Advance Directives

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

Health Net complies with all state and federal laws regarding advance directives. [Participating providers](#) are required to provide information regarding advance directives to members ages 18 and older to educate them about their rights to create an advance directive. Advance directives education provided to the member, and whether a member has executed an advance directive, must be documented in a prominent part of the member's medical record. Health Net monitors medical records to ensure compliance with requirements regarding advance directives.

## Medical Record Documentation Standards

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

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

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing impaired persons, individual personal biographical information, emergency contact, and identification of the member's assigned primary care physician (PCP)
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the offerance of advance health care directive information and education to members ages 18 and older must be included
- Routine record keeping - Department of Managed Health Care (DMHC) regulations require that the refusal of interpreter services for a Health Net member must be documented in the medical record. Department of Insurance (CDI) regulations also require that, when a minor, or friend or family member interprets at a member's request, even when a qualified interpreter is offered and available at no charge, the offer and the refusal at each visit it occurs shall be documented in the member's medical record
- Coordination of care - Notation of missed appointments, follow-up care and outreach efforts, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans
- Preventive care
  - Adult preventive care - Notation of periodic health evaluations according to the United States Preventive Services Task Force (USPSTF); assessment of immunization status and the year of the immunization(s); tuberculosis screenings and testing; blood pressure and cholesterol

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- screenings; Chlamydia screenings for sexually active females to age 25 or at risk; and mammograms and Pap tests for females
- Pediatric preventive care - Notation of age-appropriate physical exams according to the American Academy of Pediatrics (AAP); immunizations specified and within AAP and Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) requirements; anticipatory guidance for age-appropriate levels; vision, hearing, lead, and tuberculosis screenings and testing; and nutrition and dental assessments
- Perinatal preventive care - Notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, including a timely prenatal visit within the first trimester; postpartum visit three to eight weeks after delivery - this interval may be modified according to the needs of the patient, such as HEDIS timelines of 21-56 days after delivery; domestic violence and abuse screenings; HIV, alpha fetoprotein (AFP) and genetic screenings; and assessments of infant feeding status

## Medical Record Performance Measurements

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

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

## Medical Record Forms and Aids

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

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

Select any subject below:

- [Medical Record Forms and Aids](#)

## Medical Record Forms and Aids

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

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Health Net has various medical record documentation forms and aids for [participating providers](#).

- [Advance Directive Labels \(PDF\)](#)
- [Adult Health Maintenance Checklist with Standards \(PDF\)](#)
- [Annual Care for Older Adults \(COA\)/Advance Care Planning \(ACP\) Form \(PDF\)](#)
- [Audiometric Screening form \(PDF\)](#)
- [Chronic Problem List \(PDF\)](#)
- [History Form - English \(PDF\)](#)
- [History Form -Spanish \(PDF\)](#)
- [Initial Health Appointment \(IHA\) Tickler Log \(PDF\)](#)
- [Language Labels \(PDF\)](#)
- [Medication and Chronic Problem Summary \(PDF\)](#)
- [Message Log \(PDF\)](#)
- [Preventive Care Forms \(PDF\)](#)
- [Referral Log \(PDF\)](#)
- [Signature Page \(PDF\)](#)

## Member Rights and Responsibilities

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

This section contains general information on member rights and responsibilities.

Select any subject below:

- [Advance Directives](#)
- [Member Rights and Responsibilities](#)

## Advance Directives

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

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

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

An advance directive is a written document signed by a member, such as a durable power of attorney for health care (DPAHC), a declaration pursuant to the Natural Death Act, or a living will that explains the member's wish concerning a given course of medical care should a situation arise where they is unable to make these wishes

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known. The member may specify guidelines for care or delegate the decision-making authority to a family member, close friend, or other representative.

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

- The advance directive contains the date of its execution
- The advance directive is signed either by the member or in the member's name by another adult in the member's presence and at the member's direction
- The advance directive is either acknowledged before a notary public or signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675 of the California Probate Code
- If the advance directive is acknowledged before a notary public, and a digital signature is used, the digital signature must meet all of the following requirements:
  - It either meets the requirements of Section 16.5 of the Government Code and Chapter 10 (commencing with Section 22000) of Division 7 of Title 2 of the California Code of Regulations, or the digital signature uses an algorithm approved by the National Institute of Standards and Technology
  - It is unique to the person using it
  - It is capable of verification
  - It is under the sole control of the person using it
  - It is linked to data in such a manner that if the data are changed, the digital signature is invalidated
  - It persists with the document and not by association in separate files
  - It is bound to a digital certificate

For more information, select any subject below:

- [Provider Responsibilities and Procedures](#)

## Provider Responsibilities and Procedures

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

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

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

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



# Member Rights and Responsibilities

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

Members have the right to expect a certain level of service from their health care providers. Members are also responsible for cooperating with providers in obtaining health care services. Health Net developed member rights and responsibilities statements in accordance with the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). These member rights and responsibilities apply to member's relationships with Health Net, and all [participating providers](#) responsible for member care. In addition to member rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, physical or mental handicap, or disability.

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

Members have the right to:

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

Members have the responsibility to:

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



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## Prescription Drug Program

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

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

Select any subject below:

- [Compounded Medications](#)
- [Coverage Explanation](#)
- [Diabetic Supplies](#)
- [Exclusions and Limitations](#)
- [Generic Medications](#)
- [Off-Label Medication Use](#)
- [Participating Pharmacy](#)
- [Physician Self-Treatment](#)
- [Prescription Mail-Order Program](#)
- [Prior Authorization Process](#)
- [Quantity of Medication to Be Prescribed](#)
- [Recommended Drug List](#)

## Exclusions and Limitations

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

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

- Medications prescribed by a non-participating physician are not covered except when the physician's services have been authorized because of a medical emergency, illness or injury, or the physician is the authorized referring physician.
- Allergy serum.
- Appetite suppressants or medications for body weight reduction, unless medically necessary for morbid obesity, require prior authorization.
- Blood.
- Compounded medications - Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using Food and Drug Administration (FDA)-approved medications, are covered at the Level III copayment. Coverage for compounded medications is subject to prior authorization by the plan and medical necessity. Compounded medications are not covered if there is a similar proprietary product available.
- Devices other than diaphragms.
- Dietary or nutritional supplements - Medications used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to medications that are listed in the Recommended Drug List (RDL). Phenylketonuria (PKU) is covered under the medical benefit.

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- Medications prescribed for cosmetic purposes - Medications that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, anti-aging, and mental performance. Examples of medications that are excluded when prescribed for such conditions include, but are not limited to Penlac<sup>®</sup>, Renova<sup>™</sup>, Retin-A<sup>®</sup>, Vaniqua<sup>®</sup>, Propecia<sup>®</sup>, and Lustra.<sup>™</sup>
- Supply amounts (for any number of days), which exceed the Food and Drug Administration's (FDA's) or Health Net's usage recommendations.
- Hypodermic syringes and needles - Hypodermic syringes and needles are limited to disposable insulin needles and syringes and reusable pen devices.
- Medications prescribed for non-FDA-approved use.
- Medications prescribed for non-covered services.
- Lost, stolen or damaged medications.
- Prescriptions from non-participating pharmacies.
- Non-prescription (over-the-counter) medications, equipment and supplies (except insulin, diabetic supplies and as required under preventive care coverage).
- Oxygen.

## Compounded Medications

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

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

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

## Coverage Explanation

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

Health Net's prescription drug program is an option that provides members with prescription medication coverage. The member receives the highest benefit level when a Health Net PPO participating provider prescribes prescription medication on the Health Net Recommended Drug List (RDL) and the prescription order is filled by a participating pharmacy.

Most members have a multi-tier pharmacy benefit design. Tier I medications are primarily preferred generic medications and Tier II medications are primarily preferred brand-name medications. Tier III medications are primarily prescription medications specifically listed as Tier III medications or medications not listed on the Health Net RDL that are not excluded or limited from coverage. Some medications may require prior authorization by Health Net to be covered.

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## Diabetic Supplies

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

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

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

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

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

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

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

## Generic Medications

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

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

## Generic Substitution Program

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

1. Clearly indicate on the prescription "do not substitute" (DNS) or "dispense as written" (DAW). The pharmacist must make the indication on the prescription claim, and the member may be charged the higher copayment, or

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2. Request prior authorization for the brand-name medication documenting failure or clinically significant adverse effects to the generic equivalent.

## Off-Label Medication Use

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

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

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

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

Life-threatening means either or both of the following:

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

Chronic and seriously debilitating refers to:

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

## Participating Pharmacy

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

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

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

## Physician Self-Treatment

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

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

## Prescription Mail-Order Program

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

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

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

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# Prior Authorization Process

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

Prior authorization is needed for prescription medications when:

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

There are three options for submitting a prior authorization form:

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

When using the [Prescription Drug Prior Authorization or Step Therapy Exception Request Form \(PDF\)](#) it must be electronically submitted, faxed to [Pharmacy Services](#) or submitted by any reasonable means of transmission. Faxes are accepted 24 hours a day, and each request is tracked to ensure efficient handling of inquiries from physicians and members. Requests for prior authorization may also be called into [Pharmacy Services](#). Requests are processed within 24 hours for urgent requests and 72 hours for standard requests. If a health care service plan, contracted physician group or utilization review organization fails to notify a prescribing provider of its coverage determination within 72 hours for nonurgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills.

[Pharmacy Services](#) will respond via fax to advise providers the status of the request.

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

## Exigent Requests

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

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

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

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

## Participating physician group (PPG) step therapy and exception process

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

<sup>1</sup>Health and Safety Code Sections 1367.206 and 1367.241.

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

**PPGs must ensure that they have this process in place.**

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

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

## Quantity of Medication to Be Prescribed

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

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

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

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

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

## Recommended Drug List

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

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

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

The Health Net RDL is available for review or download from the [provider portal](#).

## Prior Authorizations

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

This section contains general information on prior authorizations requirements.

Select any subject below:

- [Fax Requests](#)
- [How to Secure Prior Authorization on Health Net Provider Portal](#)
- [NIA - Prior Authorization](#)
- [PPO Services Requiring Prior Authorization](#)
- [Prior Authorization Process](#)
- [TurningPoint](#)

## Fax Requests

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

The recommended way to request prior authorization for elective services is by fax. Use the [Inpatient California Health Net Commercial Prior Authorization \(PDF\)](#) or the [Outpatient California Health Net Commercial Prior](#)

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[Authorization \(PDF\)](#) to request the review of treatment and services on the Prior Authorization Requirement list. Submit routine requests at least five business days prior to the planned procedure date.

## How to Secure Prior Authorization on the Provider Portal

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

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

## NIA - Prior Authorization

Provider Type: Physicians

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

Go to the [Health Net provider website](#) for more information.

## PPO Services Requiring Prior Authorization

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

The [Commercial Prior Authorization Requirements](#) outlines the services that require prior authorization before the member receives care, except in emergencies.

## Prior Authorization Process

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

PPO members are responsible for initially contacting the [Health Net Medical Management Department](#) . Health Net also requires participating hospitals and ancillary providers to call directly for prior authorization.

Health Net members and providers may contact the Health Net Medical Management Department for prior authorization.

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The following steps outline the process when a member contacts the Health Net Medical Management Department:

- A Health Net intake coordinator answers the initial call and requests member information, physician name, member identification number, details regarding the procedure, and any other pertinent information, including other insurance
- A tracking number is assigned and used for future calls to expedite locating the correct case
- When all information is received and the procedure is approved, a Health Net Medical Management Department staff member calls the provider and assigns an authorization number, which serves as an identification number for the service
- If the request for authorization is denied, Health Net notifies the member and hospital or ancillary provider by telephone followed by a written notice in accordance with PPO guidelines. At the time of the denial, the right to appeal is communicated to both the provider and the member

If the participating hospital, ancillary provider or member does not obtain prior authorization before receiving services and the services are not for emergency care, a financial penalty may be imposed and the member's benefits are reduced, or the services may be denied in totality if deemed not medically necessary. The penalty varies by plan, but a typical example is that benefits are reduced by a percentage or dollar amount and an additional copayment may need to be satisfied.

## TurningPoint

Health Net is partnered with TurningPoint Healthcare Solutions, LLC to provide utilization management (UM) services, including prior authorization determinations for certain inpatient and outpatient musculoskeletal procedures for fee-for-service (FFS) members.

Submit requests for prior authorization to [TurningPoint](#) for the following procedures.

Orthopedic surgical procedures (including partial, total and revision surgeries)

- Acromioplasty and rotator cuff repair
- Ankle arthroplasty
- Ankle fusion
- Anterior cruciate ligament repair
- Elbow arthroplasty
- Femoroacetabular arthroscopy
- Hip arthroplasty
- Hip arthroscopy
- Hip resurfacing
- Knee arthroplasty
- Knee arthroscopy
- Knee replacement for unicompartmental or bicompartmental
- Osteochondral defect repair
- Meniscal repair
- Shoulder arthroplasty
- Shoulder fusion
- Wrist arthroplasty
- Wrist fusion

Spinal surgical procedures (including partial, total and revision surgeries)

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- Disc replacement
- Implantable pain pumps
- Kyphoplasty or vertebroplasty
- Laminectomy/discectomy
- Spinal cord neurostimulator
- Spinal decompression
- Spinal fusion surgeries

Other operations remain unchanged:

- In accordance with the Provider Participation Agreement (PPA), lack of prior authorization approval may result in nonpayment of claims.
- Emergency-related procedures do not require authorization.

## Product Descriptions

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

This section contains general information about Health Net health plans.

Select any subject below:

- [Point of Service \(POS\) Product](#)
- [Elect Open Access Two Tier Plan](#)
- [Elect Two Tier Plan](#)
- [Ambetter PPO](#)
- [Health Savings Accounts \(HSAs\)](#)
- [Leased PPO Benefit Program](#)
- [PPO Product](#)
- [Select Three Tier Plan](#)
- [Select Two Tier Plan](#)

## Point of Service (POS) Product

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

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

## Elect Open Access Two Tier Plan

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

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

Select any subject below:

- [Elect Open Access Tier 1 \(HMO\) Benefit Level](#)
- [Elect Open Access Tier 2 \(PPO Limited Benefit\) Plan](#)

## Elect Open Access Tier 1 (HMO) Benefit Level

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

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

## Elect Open Access Tier 2 (PPO Limited Benefit) Plan

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

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

## Elect Two Tier Plan

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

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

Select any subject below:

- [Elect Tier 1 \(HMO\) Benefit Level](#)
- [Elect Tier 2 \(PPO In-Network\) Benefit Level](#)

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## Elect Tier 1 (HMO) Benefit Level

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

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

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

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

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

## Ambetter PPO

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

Health Net offers the Ambetter PPO plan to individuals through Covered California™ marketplace and directly through Health Net. Individuals enrolled in the Ambetter PPO plan will obtain covered services using a select tailored network of participating Ambetter PPO providers.

The Ambetter PPO plan includes individual and family plan (IFP) products in the following counties:

### Ambetter PPO Products

| Effective date  | Product type | Counties   |
|-----------------|--------------|--|
| January 1, 2018 | IFP          | Orange Placer (partial county)<br>Los Angeles Riverside (partial county)<br>Sacramento San Bernardino (partial county)<br>San Diego Yolo |

## PCPs and Self-Referrals

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Members enrolled in Ambetter PPO are required to select a primary care physician (PCP), even though members may self-refer within the Ambetter PPO service area for services that do not require prior authorization. The PCP is listed on the member's identification (ID) card.

## Out-of-Network Providers

Members receiving care from out-of-network providers have a higher out-of-pocket cost than receiving care from in-network providers. In accordance with Covered California requirements, Health Net Ambetter PPO providers must provide advance notice to the member when proposing or considering the use of out-of-network providers for non-emergent services as part of their plan of care for a member. An updated listing of Health Net's Ambetter PPO providers is available through the [provider portal](#).

## Health Savings Accounts (HSAs)

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

Health savings accounts (HSAs) are tax-advantaged accounts set up to pay for qualified health care expenses and allow for the accumulation of savings to pay for future health care expenses. HSA funds can be withdrawn for any reason and withdrawals are not taxable when used for qualified health care expenses. Accounts are set up with banks and other qualified financial institutions. Contributions are tax-free and there is no time limit for using HSA funds, as funds rollover from year to year.

Participation in an HSA requires enrollment in an HSA-compatible, high-deductible health plan. The high deductible makes the premium less expensive. In California, Health Net offers members high-deductible HSA-compatible PPO plans.

To ensure proper reimbursement, participating providers should bill Health Net for services first; providers should not collect deductibles, copayments or coinsurance at the time of service. Refer the discussion of [Health Savings Account Claims Processing](#) in the Claims and Provider Reimbursement section for more information.

## Leased PPO Benefit Program

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

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

## PPO Product

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



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## Health Net (Flex-Net) Indemnity Benefit Level

The Health Net (Flex-Net) Indemnity (out-of-network) benefit level plan affords members the freedom to seek treatment from any out-of-network licensed health care provider. Certain prior authorization requirements may apply; refer to the [Prior Authorization](#) topic for more information. The member is responsible for the deductible, coinsurance amount and any amount billed by the provider above the maximum allowable amount covered by the plan.

### PPO Product

The PPO product offers two benefit levels, in-network and out-of-network, depending on which type of provider a member uses and how the member obtains care. Members receiving covered services and care from PPO in-network providers have lower out-of-pocket costs than when receiving care from out-of-network providers. The member may choose either benefit level when seeking care.

#### In-Network Benefit Level

PPO in-network plans afford comprehensive care at lower out-of-pocket costs to members who use the preferred provider network. Members are free to obtain treatment from any provider in the network without a referral from a primary care physician. However, prior authorization requirements may apply as stated in the member's [Certificate of Insurance](#) (COI). A member's failure to obtain a required prior authorization may result in penalty that reduces benefits otherwise payable. Out-of-pocket expenses for members are limited to the copayment or coinsurance amounts designated for particular benefits, and deductibles and penalties for failure to obtain required prior authorizations that apply. Refer to the [Prior Authorization](#) section for more information.

Behavioral health and substance abuse services are administered by MHN.

#### Out-of-Network Benefit Level

PPO out-of-network plans afford members the freedom to seek covered services and treatment from any out-of-network licensed health care provider, but at a higher out-of-pocket cost than at the in-network level. Prior authorization requirements may apply as stated in a member's COI. A member is responsible for the deductible, coinsurance amount, and any amount billed by the provider above the maximum allowable amount (less any applicable financial penalties for failure to obtain a required prior authorization) covered by the plan.

PPO providers must provide advance notice to the member when proposing or considering the use of out-of-network providers for non-emergent services as part of their plan of care for a member.

## Select Three Tier Plan

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

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

Select any subject below:

- [Select Tier 1 \(HMO\) Benefit Level](#)

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- [Select Tier 2 \(PPO In-Network\) Benefit Level](#)
- [Select Tier 3 \(Indemnity Out-of-Network\) Benefit Level](#)

## Select Tier 1 (HMO) Benefit Level

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

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

## Select Tier 2 (PPO In-Network) Benefit Level

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

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

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

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

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

## Select Two Tier Plan

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

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

Select any subject below:

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

## Select Tier 1 (HMO) Benefit Level

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

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

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

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

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

## Provider Oversight

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

This section contains general information on provider oversight requirements and monitoring.

Select any subject below:

- [Fraud, Waste and Abuse](#)
- [Monitoring Provider Exclusions](#)
- [Contractual Financial and Administrative Requirements](#)
- [Facility and Physician Additions, Changes and Deletions](#)
- [Service and Quality Requirements](#)

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## Participating Physician Groups (PPG)

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

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

- Alerting the delegated entity regarding possible areas of non-compliance
- Furnishing information regarding regulations
- Developing corrective action plans (CAPs)
- Sharing best practices
- Offering guidance regarding on-site review by outside agencies

## Delegation Oversight Committee

The Health Net Delegation Oversight Department is under the direction of the Senior Vice President of Operations. The Delegation Oversight Committee (DOC) is chaired by the Vice President of Delegation Oversight. The committee meets bi-monthly and is comprised of but not limited to senior management representatives from the Health Net Provider Network Management, QI, Health Care Services, Medical Management, Provider Services, Member Services, Actuarial, Appeals and Grievances (A&G), Claims, Encounters, Credentialing, Delegation Oversight, Program Accreditation, and Finance departments. The committee reviews monthly compliance reports and hears recommendations from the Delegation Oversight Workgroup (DOW) and other departments regarding provider compliance deficiencies. The committee collaboratively makes decisions to remedy noncompliance as quickly as possible. Those actions may include closer monitoring by the oversight staff, developing CAPs, escalating to Joint Operations Committees revoking delegation of specific functions, imposing progressive sanctions (such as freezing enrollment and financial sanctions), and when necessary, notifying providers of contract breaches and contract termination.

## Credentialing and Recredentialing

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

## HEDIS<sup>®</sup> 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.

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## Member Complaints, Appeals and Grievances

The Health Net Member Services or Appeals and Grievances Departments work to resolve individual member complaints. All member complaints and inquiries are entered into a database 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 QI staff reviews the reports. A 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 forwarded to the Health Net Clinical Appeals and Grievances Department, 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 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](#).

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## Fraud, Waste and Abuse

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

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

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

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

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

## Monitoring Provider Exclusions

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

The Centers for Medicare & Medicaid Services (CMS) 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](#).

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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

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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.

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## 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).

## Contractual Financial and Administrative Requirements

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

This section contains general information on contractual financial and administrative requirements.

Select any subject below:

- [Contracts with Ancillary Providers](#)
- [Discrimination against Health Care Professional Prohibited](#)
- [Use of Performance](#)

## 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.

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- 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.

## 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.

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# 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](#)
- [Facility and Satellites](#)
- [PPG and Hospital Termination](#)
- [Provider Online Demographic Data Verification](#)
- [Provider Outreach Requirements](#)

## Overview

Participating Physician Groups (PPG) | Ancillary | Hospitals

A [participating provider](#) that expands its capacity by adding new or satellite facilities or new participating physicians or other subcontracting providers must notify Health Net in writing at least 90 days before the addition. According to the terms of the Provider Participation Agreement (PPA), the participating provider agrees that Health Net has the right to determine whether the new or satellite facilities or the new participating physicians are acceptable to Health Net.

## Addition of New Physicians, Providers or Facilities

Until Health Net approves new subcontracting providers (for example, primary care physicians (PCPs), specialists and ancillary providers), the providers are not allowed to provide covered services under the Health Net PPA. Health Net must be notified in writing at least 90 days before the addition.

Health Net is free to deny participation to any new subcontracting providers and is not obligated to state a cause or explain the denial of the addition or provide the facility, provider or subcontracting providers with any right to appeal or any other due process. Health Net's decision in these cases is final and binding.

In addition, hospitals, ancillary providers and participating physician groups (PPGs) are responsible for providing Health Net with copies of the standard agreements used for their subcontractors. Health Net reviews these standard agreements to ensure compliance with regulatory requirements<sup>1</sup> and directs the facility to make any changes required in order to meet the requirements. Health Net requires hospitals, ancillary providers and PPGs to send sample forms to Health Net for review if they make any changes to their standard agreements or replace them with new standard agreements.

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Hospitals, ancillary providers and PPGs must provide Health Net with a copy of the signature page for each subcontractor. Physicians or other subcontractors must be credentialed before they are added to Health Net's network. Hospitals, ancillary providers and PPGs must also provide Health Net a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals, ancillary providers and PPGs are also responsible for informing Health Net when they cease to use a specific subcontractor or when they add a new subcontractor. Health Net periodically sends each hospital, ancillary provider and PPG a list of the physicians or subcontractors Health Net shows as active and under contract with the participating provider. Hospitals, ancillary providers and PPGs are required to review this list and notify Health Net of any additions or deletions. At least monthly, hospitals, ancillary providers and PPGs must provide Health Net with a list of additions, deletions and address changes, as well as a complete listing annually.

For PPGs only, the Active Physicians Listing is available monthly on the [Health Net provider website](#) as an administrative report. Select Provider Reports under Welcome. This report provides PPGs a means to review and revise their records on a monthly basis and communicate physician demographic changes and terminations to Health Net. Additionally, this listing is used by the Health Net Provider Network Management Department to validate PCP and specialist information with the PPG on a quarterly basis.

Hospitals, ancillary providers and PPGs must furnish Health Net copies of any amendments to a contract with a participating provider within 20 days of execution.

<sup>1</sup>Medicare Managed Care Manual, Chapter 11, Section 100.4.

## 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.



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## PPG and Hospital Termination

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

Participating physician groups (PPGs) and hospitals must notify the Health Net regional Provider Network Management Department in writing as stated in their Provider Participation Agreement (PPA).

Health Net offers transition of care assistance to members who request to complete a course of treatment of covered services by a terminated provider. Refer to the [Continuation of Care Assistance](#) discussion under the Utilization Management topic.

## Provider Online Demographic Data Verification

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

On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website under ProviderSearch. According to the terms of the Provider Participation Agreement (PPA), participating providers are required to provide a minimum of 30 days advance notice of any changes to their demographic information. If the change pertains to the status of accepting new patients or no longer accepting new patients, you must notify Health Net or the applicable PPG within five business days.

Providers directly contracting with Health Net must notify Health Net of changes to by completing the online form or by reaching out to your provider relations and contracting specialist (formally provider network administrator). The online form is available on the provider website. Providers must have privileges to update and submit changes online.

Providers contracting through a PPG must notify the PPG directly of changes, and the PPG notifies Health Net. PPGs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS).

If a provider sees patients at multiple locations, the provider should review address, phone number, fax number, and office hours for all locations to ensure data accuracy.

## Demographic Information

Providers' demographic data information should include the following:

- Name
- Alternate name
- Address
- Telephone number
- Fax number

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- 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

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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<br>1-877-688-9891 (TDD)<br><a href="http://www.hmohelp.ca.gov">www.hmohelp.ca.gov</a> | HMO, POS, HSP, Medi-Cal |
| California Department of Insurance (CDI) | 1-800-927-4357<br><a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>                     | 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:

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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](#)
- [Threshold Languages and Language Assistance Codes](#)
- [Authorization and Referral Timelines](#)
- [Credentialing and Recredentialing](#)
- [Obtaining Interpreter Services](#)

## Access to Care and Availability Standards

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

Health Net's access and availability policies, procedures and guidelines for practitioners, providers and health care facilities providing primary care, specialty care, behavioral health care, and ancillary services are in accordance with applicable federal and state regulations, contractual requirements and accreditation

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standards. These access standards are regulated by the California Department of Insurance (CDI) and comply with the National Committee for Quality Assurance (NCQA).

Note: Behavioral health and chemical dependency services are administered by Health Net.

Health Net and its participating providers are required to demonstrate that, throughout the geographic regions for Health Net's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible at reasonable times to all Health Net members. Additionally, Health Net and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within a reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practice. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

## Member Notification

Members are notified annually, via member newsletters or the [Evidences of Coverage](#) (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

## Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioner (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instruction on after-hours access to medical care.

## After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, seven days a week, and PCPs are required to have an appropriately licensed professional back up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instruction on after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) must return telephone calls and pages within 30 minutes and be available 24 hours a day, seven days a week. The PCP or on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room, as medically necessary.

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Additionally, Health Net provides triage and screening services 24 hours a day, seven days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, seven days a week.

## After-Hours Sample Scripts

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues. Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has designed an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can utilize as a guide for staff answering the telephone. For PPGs or physicians who use an automated answering system, this template can be used as a script to advise members on how to access care. Health Net's after-hours scripts provide easy to use messaging examples on how to direct members to emergency care services and who to talk to when they need urgent medical advice.

Health Net makes the script in the following threshold languages:

- [English \(PDF\)](#)
- [Spanish \(PDF\)](#)
- [Chinese/Cantonese \(PDF\)](#)

After-hours scripts are available in additional languages upon request. Contact the [Provider Network Management, Access & Availability Team](#) for more information.

## Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the 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 condition of the member 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.

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Health Net encourages answering services follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
- If language assistance is needed, offer the member interpreter services, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted.

In the event of a hospitalization, the PPG or hospital must contact [Hospital Notification Unit](#) within 24 hours or the next business day of the admission.

The answering service should document all calls. Answering services frequently have a high staff turnover, so providers should monitor the answering service to ensure emergency procedures are followed.

## Triage and/or Screening Services/Nurse Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), Health Net provides 24-hour-a-day, seven-day-a-week triage or screening services by telephone. This program is a service offered in conjunction with the PCP and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment and advice. The [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

Health Net and its participating providers do not discriminate against members who have physical disabilities. Participating providers are required to provide reasonable access for disabled members in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers are to reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including

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ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

## Appointment and Referrals

PPO and EPO members may seek care through participating providers or out-of-network providers according to their benefit plans.

## Missed Appointments

According to Health Net's Medical Records Documentation Standards policies and procedures (KK47-121230), missed appointment follow-up and outreach efforts to reschedule must be documented in the member's record.

## Appointment Rescheduling

According to new timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly; in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

## Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of 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.

## Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within Health Net's service area 24 hours a day, seven days a week.

## Providing Emergency and Urgent Care Services in the PCP's Office



The physician, registered nurse (RN) or physician assistant (PA) on duty is responsible for evaluating emergency and urgent care members in the office and making the decision to further evaluate and treat, summon an ambulance for transport to the nearest emergency room, directly admit to the hospital, or refer to a same-day visit at another provider or urgent care facility. Provider Telephone Assessment

Telephone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs, and nurse practitioners (NPs)) and only in accordance with established standards of practice.

## Telehealth

**Telehealth** services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between Health Net and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the original site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member. The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

## Interpreter Services

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

## Cultural Considerations

Health Net and its participating providers must ensure that services are provided in a culturally competent manner to all members, including those who are limited-English proficient (LEP) or have limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to [Language Assistance and Cultural Competency \(Hospitals\)](#) for more information.

## Minor Consent Services

As defined in 42 CFR 2.14 (a) the term "minor" means a person who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, age 18 years.

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent to access or obtain. The health care practitioner is not permitted to inform a parent or legal guardian without the minor's consent. Minors under age 18 may consent to medical care related to:

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- Prevention or treatment of pregnancy (except sterilization) - California Family Code (CFC) §6925.
- Family planning services, including the right to receive birth control - CFC§6925.
- Abortion services (without parental consent or court permission) - American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4<sup>th</sup> 307 (1997)..
- Sexual assault, including rape diagnosis, treatment and collection of medical evidence; however, the treating provider must attempt to contact the minor's parent/legal guardian and note in the minor's treatment record the date and time of the attempted contact and whether or not it was successful. This provision does not apply if the treating provider reasonably believes that the minor's parent or guardian committed the sexual assault on the minor or if the minor is over age 12 and treated for rape - CFC §6927 and CFC §6928.
- HIV testing and counseling (for children ages 12 and older) - CFC§6926..
- Infectious, contagious, communicable, and sexually transmitted diseases diagnosis and treatment (for children ages 12 and older) - CFC§6926.
- Drug or alcohol abuse (for children ages 12 and older) treatment and counseling except for replacement narcotic abuse treatment - CFC§6926(b).
- Outpatient behavioral health treatment or counseling services (for children ages 12 and older) if in the opinion of the attending provider the minor is mature enough to participate intelligently in the outpatient or residential shelter services and the minor would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or is the alleged victim of incest or child abuse - CFC§6924.
- Skeletal X-ray - a health care provider may take skeletal X-rays of a child without the consent of the child's parent/legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of it - Cal. Penal Code CFC §11171.
- General medical, psychiatric or dental care if all of the following conditions are satisfied: (1) The minor is age 15 or older, (2) The minor is living separate and apart from their parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence, (3) The minor is managing their own financial affairs, regardless of the source of the minor's income. If the minor is an emancipated minor they may consent to medical, dental and psychiatric care - CFC § 6922(a) and§ 7050(e).

## Routine Authorization (Pre-Service) – Deferral Needed

An initial decision may be deferred for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee,” in accordance with Section 1367.03(a)(5)(H), and:

- Additional clinical information is required.
- Consultation by an expert reviewer is required.
- Additional examination or tests are to be performed.
- The Plan can provide justification upon request by the State of the need for additional information and how it is in the member's interest. (42 CFR 438.210(d) 438.404).

The decision may be deferred for an additional 14 calendar days (not to exceed a total of 28 calendar days from the date of receipt of the original request) only if: The member or the member's provider requests an extension, or the Plan can provide justification upon request by the State of the need for additional information and how it is in the member's interest.



Written Notification, Notice of Action – Deferral is sent to the enrollee and requesting provider within the initial five working days from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

- Specify the additional information requested but did not receive; requesting only that information that is reasonably necessary to make a decision.
- Provide the anticipated date of decision.
- Advise the requesting provider that:  
"In accordance with Section 1367.03(a)(5)(H):
  - If this delay to obtain additional information and resulting delay will have a detrimental impact on the health of the member, you must contact the Plan.
  - If this delay will not have a detrimental impact on the health of the member, you must document this in the member record."
- Advise the member that they have a right to file a grievance to dispute the delay.

### Determination Timeline for a Decision following a Deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received:  
If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

### Expedited Authorization (Pre-Service) - Deferral Needed

An initial decision may be deferred for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee," in accordance with Section 1367.03(a)(5)(H), and:

- Additional clinical information is required.
- Requires consultation by an expert reviewer.
- Additional examination or tests are to be performed.

Written Notification, Notice of Action – Deferral: Written notification is sent to the member and requesting provider within the initial 72 hours from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

- Specify the additional information requested; requesting only that information that is reasonably necessary to make a decision.
- Provide the anticipated date of decision.
- Advise the requesting provider that:

"In accordance with Section 1367.03(a)(5)(H):

- If this delay to obtain additional information will have a detrimental impact on the health of the member, you must contact the Plan.
- If this delay will not have a detrimental impact on the health of the member, you must document this in the member record."



## Determination Timeline for a Decision following a Deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received:

If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

## Quality Assurance

Health Net has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, Health Net monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, Health Net reviews and evaluates the information available to Health Net regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service telephone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible to monitor data provided by Health Net regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

## Monitoring and Reporting

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment as indicated. Plan-level results and applicable actions for improvement are communicated to practitioners, providers and PPGs through the Quality Improvement Committee.

At least annually, Health Net surveys providers to measure and evaluate member access. Listed below are Health Net's performance goals for access-related, time-elapsed provider criteria:

### Health Net EPO and PPO Plans Medical Appointment Access Standards



| ACCESS MEASURE  | STANDARD  | PERFORMANCE GOAL |
|---|---|------------------|
| Non-urgent appointments for primary care - regular and routine care (PCP) | Appointment within 10 business days of request  | 70%              |
| Urgent care (PCP) services that do not require prior authorization        | Appointment within 48 hours of request  | 70%              |
| Non-urgent appointments with specialist (SCP)                             | Appointment within 15 business days of request  | 70%              |
| Urgent care services (SCP and other) that require prior authorization     | Appointment within 96 hours of request  | 70%              |
| After-hours care (PCP)  | Ability to contact on-call physician after hours within 30 minutes for urgent issues.<br><br>Appropriate after hours emergency instructions | 90%              |
| Non-urgent ancillary services for MRI/mammogram/physical therapy          | Appointment within 15 business days of request  | 70%              |
| In-office wait time for scheduled appointments (PCP and SCP)              | Not to exceed 30 minutes  | 70%              |

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and Provider After-Hours Availability Survey (PAHAS) conducted via telephone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS<sup>®1</sup>) survey.

<sup>1</sup>CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

**Health Net Commercial (HMO, POS, PPO, EPO, HSP) Plans Appointment Access Standards – Behavioral Health**

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| ACCESS MEASURE   | STANDARD   | PERFORMANCE GOAL  |
|--|--|---|
| Urgent care <sup>1</sup>   | Within 48 hours                                    | 90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours |
| Non-life threatening emergency (NLTE) <sup>1</sup>   | 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 <sup>1</sup>   | Immediately  | 100% compliance with immediate referral to care   |
| Rescheduled Appointments <sup>2</sup>  | 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 <sup>3</sup>   | Appointment within 15 business days of request     | 70%   |
| Non-urgent appointment with non-physician behavioral health care provider for routine care <sup>3</sup>  | 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 <sup>3</sup> | Appointment within 48 hours of request             | 70%   |
| Urgent care appointment with non-physician behavioral health care provider or  | Appointment within 96 hours of request             | 70%   |

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| ACCESS MEASURE   | STANDARD                           | PERFORMANCE GOAL |
|--|------------------------------------|------------------|
| behavioral health care physician (psychiatrist) that requires prior authorization <sup>3</sup>   |                                    |                  |
| Non-urgent follow-up appointment with non-physician behavioral health care provider <sup>3</sup> | Within 10 business days of request | 80%              |

<sup>1</sup>Assessed through care management software.

<sup>2</sup>Assessed through annual BH member experience survey (ECHO).

<sup>3</sup>Assessed through annual Provider Appointment Availability Survey (PAAS).

## Corrective Action

Health Net investigates and implements corrective action when timely access to care standards, as required by Health Net's Appointment Accessibility for all lines of businesses appointment access policy and procedure (CA.NM.05), is not met.

Health Net uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one or more metrics are noted as being noncompliant:

- Appointment access - PPGs that do not meet Health Net's 70% 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

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- 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.

## Availability Corrective Action

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through the Quality Improvement Committee or through the activities of Provider Network Management.

## Availability Standards

Health Net provides established availability standards and performance goals for providers. At least annually, Health Net measures, evaluates and reports geo-access and provider availability. Listed as follows are Health Net's performance goals for geo-access and provider availability-related criteria:



## Health Net EPO and PPO Geo-Access Standards\*

| Availability Standards   | Performance Threshold   |
|--|---|
| One PCP within 15 miles or 30 minutes from residence or workplace  | 90% or more of practitioner/provider network meet compliance rate |
| One SCP (including high volume SCP) within 15 miles or 30 minutes from residence or workplace  | 90% or more of practitioner/provider network meet compliance rate |
| One behavioral health practitioner (BHP) (including high volume substance abuse providers) within 15 miles or 30 minutes from residence or workplace   | 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 emergency room within 15 miles or 30 minutes from residence or workplace   | 90% or more of practitioner/provider network meet compliance rate |
| One urgent care center (must be available for extended hours to address CDI & T10§2240.1(b) (4) minimum basic health care service hours) within 20 miles or 30 minutes from residence or workplace | 90% or more of practitioner/provider network meet compliance rate |
| One ambulatory clinic (such as urgent care center, ambulatory surgery center and free-standing renal dialysis facility) 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 and pharmacy) within 15 miles or 30 minutes from residence or workplace   | 90% or more of practitioner/provider network meet compliance rate |

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## Provider Availability Standards

| Availability Standards                                    | Performance Threshold                          |
|---|--|
| Member to full time equivalent (FTE) PCP ratio            | 2,000:1  |
| Member to FTE physician                                   | 1,200:1  |
| Member to SCP ratio                                       | 1,200:1  |
| Member to BHP (including substance abuse providers) ratio | 5,000:1  |
| Percent PCPs open practice                                | 85% open practice (PCPs accepting new members) |
| Percent SCPs open practice                                | 85% open practice (SCPs accepting new members) |

\*Certain rural 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 15-mile/30-minute standard.

## Behavioral Health Access Measurement

Health Net's access and availability policies, procedures and guidelines for providers and health care facilities providing behavioral health care 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 National Committee for Quality Assurance (NCQA), and the California Department of Insurance (CDI).

Health Net has a documented system for monitoring and evaluating provider availability and accessibility of care. At least annually, Health Net monitors access to care guidelines to measure behavioral health access performance and confirm compliance. Participating physician groups (PPGs) are also responsible to monitor data regarding their adherence to the following performance goals. Listed below are the appointment access provider criteria and performance goals for:

### EPO/PPO

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## Appointment Access Standards - Behavioral Health

| Access Type  | Provider Guidance       | Standard/Performance Goal  |
|--|-------------------------|--|
| Initial non-urgent appointment with physician (Psychiatrist) for routine care                      | Within 15 business days | 90% or more of physicians (psychiatrist) offer an initial non-urgent appointment within 15 business days                       |
| Initial non-urgent appointment with non-physician behavioral health care provider for routine care | Within 10 business days | 90% or more of non-physicians behavioral health care providers offer an initial non-urgent appointment within 10 business days |
| Urgent care  | Within 48 hours         | 90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours                |
| Non-life threatening emergency (NLTE)  | 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  | Immediately             | 100% compliance with immediate referral to care  |

Access results are obtained via the Provider Appointment Availability Survey (PAAS), the Health Net Behavioral Health Access Survey, Affiliate Behavioral Health Member Satisfaction Survey and the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)

## Threshold Languages and Language Assistance Codes

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

Health Net established its threshold languages of Spanish, Chinese and Korean through analysis of United States Census data and direct assessment of Health Net members' preferred spoken and written languages through member mailings.

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Participating providers may request member race and ethnicity information from Health Net for lawful purposes, and may verify member language preferences by contacting the appropriate Provider Services Center. For reference, the Language Assistance Codes document is located in the [Health Net provider portal](#)> Provider Reports under Welcome.

## 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](http://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.

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For additional information, refer to:

- [Utilization Management Timeliness Standards - Medicare \(PDF\)](#)
- [Utilization Management Timeliness Standards - Commercial \(PDF\)](#)

## 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<sup>®</sup>) 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.

## Obtaining Interpreter Services

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

To obtain interpreter services for a Health Net member, call the telephone number on the member's identification (ID) card.

## Using Family, Friends and Minors and Interpreters Obtaining Interpreter Services

Department of Managed Health Care (DMHC) regulations state that participating providers must fully inform members that they have the right to not use family, friends or minors as interpreters, and that interpreters are available to them at no cost. Providers may not require members to use family, friends and minors as interpreters.

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California Department of Insurance (CDI) regulations discourage the use of family members and friends, and strongly discourage the use of minors, as interpreters for members. In an emergency situation, a minor can only be used as an interpreter if the minor demonstrates the ability to interpret complex medical information and the member is fully informed that an interpreter is available to him or her at no cost. Providers must also fully inform the member that the member has the right not to use family, friends or minors as interpreters.

## Quality Improvement

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:

- [Decision Power Disclaimer](#)
- [Decision Power Program](#)

## Decision Power Disclaimer

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net members have access to Decision Power<sup>®</sup> through their current enrollment with Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies. Decision Power is not affiliated with Health Net's provider network. Decision Power is not part of Health Net's commercial medical benefit plans and it may be revised or withdrawn without notice. However, Decision Power is part of Health Net's Medicare Advantage benefit plans for the plan year. Health Net and Decision Power are registered service marks of Health Net, LLC. All rights reserved.

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## Decision Power Program

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

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Health Net's Decision Power® (HMO, EPO, PPO, Medicare Advantage) program provides an integrated, health management solution to improve the health and quality of life for Health Net members. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced clinical staff can assist members at-risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. Decision Power 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](http://www.healthnet.com). Members have access to the secure Health Profile, RealAge Test (health assessment) and Lifestyle Management 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 ([Commercial/Medicare Advantage \(PDF\)](#)) to:

- The Craving to Quit tobacco cessation program, available to commercial members).
- The [Health Coaching Program](#) (available to Commercial and Medicare Advantage 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

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

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

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

## Care Management

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

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

**Health Nets Special Needs Plan (SNP) care management (CM)- All SNP and CMC members are automatically assigned CM during the month of CMC membership enrollment with the plan and becoming eligible with Health Net ( Health Net or PPG CM assigned per delegation).**

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

## Health Education Program

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

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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,

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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.

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- 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 (HbA1c) screening every three months
    - Annual microalbumin creatinine urine screening
    - Blood pressure screening at every visit

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- 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

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- 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.

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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<sup>®</sup>. Members may access the library by contacting the [Health Net Member Services Department](#).

# Responsibilities for Health Education Programs

## Program Delivery Site

Participating physician groups (PPG) and its participating providers should dedicate and maintain a physical environment or setting conducive to the delivery of health education programs and optimal learning and ensure that is appropriate for its Health Net membership. Specifically:

- Member education must not occur in an examination or a waiting room during clinic hours.
- All programs should be conducted onsite or at an appropriate offsite location.
- The sites must be accessible to individuals who have physical limitations.

## Program Evaluation and Tracking

Health Net recommends that groups evaluate all classes and seminars using a written participant evaluation form. The evaluation form should include an overall satisfaction question using a five-point rating scale, such as:

|                     |                |           |                    |                        |
|---------------------|----------------|-----------|--------------------|------------------------|
| 5                   | 4              | 3         | 2                  | 1                      |
| Extremely Satisfied | Very Satisfied | Satisfied | Not Very Satisfied | Extremely Dissatisfied |

Written participant evaluation forms are not required for one-to-one counseling sessions.



PPGs should conduct follow-up telephone calls or use other means to evaluate the quality of one-to-one counseling sessions.

## Program Promotion

PPGs should promote all programs to Health Net members and PPG staff. Health Net encourages PPGs to mail promotional materials to Health Net members at least once per year to promote all health education programs. Suggested promotional activities include:

- Flyers and posters in waiting areas.
- Medical group newsletters via direct mail.
- Telephone recordings.

PPGs may not use the Health Net corporate logo on material without Health Net's permission.

## Record-keeping Responsibilities

PPGs should use and maintain appropriate medical and non-medical records (for example, attendance lists, evaluation forms, patient education sign-in sheets, and documentation of feedback to physicians).

Specifically, PPGs should maintain the following documentation:

- Attendance records or one-to-one education sign-in sheets identifying Health Net members.
- Written program evaluations for all programs (except one-on-one counseling).
- A system to document smoker identification and referrals to a smoking cessation program.
- Minutes from advisory committee meetings.
- A physician feedback system of participant attendance and progress in the diabetes and early prenatal programs, which provides a link between the referring physician, patient, and health education program:
  - Attendance feedback is documented in the member's medical record or in a central file.
  - A random sampling of medical records or copies of feedback records may be reviewed during the annual site evaluation.

PPGs may also document the member's progress, response to education and attendance in other programs and share this information with the member's physician.

## Speakers Bureau

Participation in Health Net's Speakers Bureau program is optional. Participating physician groups (PPGs) are asked periodically to provide presentations or screenings to Health Net employer groups.

For more information, select any subject below:

- [Smoking Cessation Program](#)



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# 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<sup>1</sup>

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.

<sup>1</sup>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](http://www.kickitca.org).

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## 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:

- [Behavioral Health Services](#)
- [Decision Power Program](#)

## 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:

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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.

## Decision Power Program

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

Health Net's member wellness portal is a central hub for all of the wellness programs and activities. The wellness programs were created to engage people in their health with personalized tools and achievable goals. Members can feel confident in their ability to make positive and lasting behavioral changes.

## Language Assistance Program and Cultural Competency

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

This section contains general information on Health Net's cultural and linguistic services.

Select any subject below:

- [Language Assistance Program and Cultural Competency](#)
- [Language Assistance Program and Cultural Competency \(Hospitals only\)](#)

## Language Assistance Program and Cultural Competency

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

### Riverside and San Bernardino (Medi-Cal)

Riverside and San Bernardino County Medi-Cal providers must receive interpreter services through [Molina Healthcare](#).

### All Other Counties

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The Health Care Language Assistance Regulations require all health plans to provide language assistance and culturally responsive services to members with limited English proficiency (LEP), limited reading skills, who are deaf or have a hearing impairment, or who have diverse cultural and ethnic backgrounds. To comply with this requirement, Health Net created the Language Assistance Program (LAP). Health Net's LAP offers interpreter services to members to ensure that Health Net members with LEP are able to obtain language assistance while accessing health care services. Health Net's LAP supports Health Net members' linguistic and cultural needs. Additionally, Health Net offers interpreter support and requires all participating providers to take cultural competency courses. Providers are encouraged to take courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to [OMH Think Cultural Health](#).

Health Net participating providers must comply with Health Net's LAP as defined below.

## Compliance Requirements

Health Net participating providers, including case management and utilization management (UM)-delegated providers, are required to support Health Net's LAP by using the following:

- Interpreter services - Use qualified interpreters for members with LEP. Interpreter services are provided by Health Net at no cost to providers or members. Telephone interpreters are available in more than 150 languages. Advance notice for telephone interpreters is not required.
- Translation services - Provide Health Net, upon request and in a timely manner, with the documents sent to members. If a Health Net member requests translation or an alternative format of an English document that was produced by a delegated PPG on Health Net's behalf, the provider must refer the member to the Health Net Member Services phone number listed on the member's identification (ID) card. When Member Services receives the request from the member, Health Net contacts the provider requesting a copy of the specific English document for translation or alternative format. The provider must submit the document within 48 hours of Health Net's request.
- Tagline and non-discrimination notice - Include a Health Net-specific tagline and non-discrimination notice with vital documents going to Health Net members.

| Commercial                                 | CalViva Health   | Community Health Plan of Imperial Valley   | Medi-Cal   |
|--|--|--|--|
| Commercial Non-discrimination Notice (PDF) | Non-discrimination Notice CalViva Health (English) (PDF) | Non-discrimination Notice Community Health Plan of Imperial Valley (English) (PDF) | Non-discrimination Notice Medi-Cal (English) (PDF) |
|  | Non-discrimination Notice CalViva Health (Hmong) (PDF)   | Non-discrimination Notice Community Health Plan of Imperial Valley (Spanish) (PDF) | Non-discrimination Notice Medi-Cal (Arabic) (PDF)  |

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| Commercial | CalViva Health   | Community Health Plan of Imperial Valley | Medi-Cal  |
|------------|--|--|---|
|            | Non-discrimination Notice CalViva Health (Spanish) (PDF) |  | Non-discrimination Notice Medi-Cal (Armenian) (PDF)   |
|            |  |  | Non-discrimination Notice Medi-Cal (Cambodian) (PDF)  |
|            |  |  | Non-discrimination Notice Medi-Cal (Chinese) (PDF)    |
|            |  |  | Non-discrimination Notice Medi-Cal (Farsi) (PDF)      |
|            |  |  | Non-discrimination Notice Medi-Cal (Hmong) (PDF)      |
|            |  |  | Non-discrimination Notice Medi-Cal (Korean) (PDF)     |
|            |  |  | Non-discrimination Notice Medi-Cal (Russian) (PDF)    |
|            |  |  | Non-discrimination Notice Medi-Cal (Spanish) (PDF)    |
|            |  |  | Non-discrimination Notice Medi-Cal Tagalog) (PDF)     |
|            |  |  | Non-discrimination Notice Medi-Cal (Vietnamese) (PDF) |

- Member complaint/grievance forms - Provide translated member grievance forms (provided under the Forms section of the provider library) to members upon request.
- PPO member complaints - Inform PPO members that they can submit grievances verbally or in writing by contacting the Health Net Member Services Department using the contact information provided on the back of the member identification (ID) card.

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- Independent Medical Review (IMR) Application - Locate translated IMR applications on the Department of Managed Health Care (DMHC) website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov) and make them available to members upon request.
- Medical record documentation - Document the member's language preference (including English) and the refusal or use of interpreter services in the member's medical record.

## Interpreter Services

Health Net offers 24-hour [access to interpreter services](#) at no cost. To obtain interpreter services, members and providers can contact Health Net Member Services at the phone number located on the member's ID card. Telephone interpreters are available at the time of the appointment without prior arrangement. Allow adequate time before the appointment to get the telephone interpreter on the line.

Non-English interpreter services include:

- Qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics.
- Telephone interpreters available in more than 150 languages and on short notice in support of last-minute appointments to meet the revised access and availability standards.
- Sign language interpreter services are available when requested a minimum of 10 business days in advance of the appointment.
- Support to address common communication challenges across cultures.
- Oral translations of member materials in more than 150 languages.

## Provider Responsibilities

Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that interpreters are available at the time of the appointment.
- Ensure that members with LEP are not subject to unreasonable delays in the delivery of services, including accessing providers after hours.
- Provide interpreter services at no cost to members.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to members with LEP that are as effective as those provided to members without LEP.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in their medical record. Providers are strongly encouraged to document the use of any interpreter in the member's record.
- Provide translated member grievance forms to members upon request.

Providers are prohibited from:

- Requesting or requiring an individual with LEP to provide their own interpreter.
- Relying on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Relying on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:

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- 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.

Providers are responsible to provide translated care plans in threshold languages to members with LEP and/or their caretakers. Care plans must be written at a 6<sup>th</sup> grade reading level for Medi-Cal and 8<sup>th</sup> grade reading level for Commercial members. Health Net provides the translations in threshold languages upon request with documentation that the content is at the applicable reading level. Refer to the provider Interpreter Services Quick Reference Guide for assistance.

- [Commercial and Medi-Cal Interpreter Services Quick Reference Guide \(PDF\)](#)
- [CalViva Health Interpreter Services Quick Reference Guide \(PDF\)](#)
- [Community Health Plan of Imperial Valley Interpreter Services Quick Reference Guide \(PDF\)](#)

A Language Identification Poster is available to print and post in providers' offices.

- [Commercial, Medi-Cal Language Identification Poster \(PDF\)](#)
- [CalViva Health Language Identification Poster \(PDF\)](#)
- [Community Health Plan of Imperial Valley Language Identification Poster \(PDF\)](#)

For more information about how to work with an interpreter, refer to the [Health Industry Collaboration Effort \(ICE\): Provider Tools to Care for Diverse Populations – Health Net \(PDF\)](#), [Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – Community Health Plan of Imperial Valley \(PDF\)](#) or [Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – CalViva Health Industry Collaboration Effort \(PDF\)](#).

## Cultural Competency Training

All Health Net participating providers must take cultural competency training. We suggest that you take one of the trainings offered by the Office of Minority Health (OMH). The trainings are computer-based training for health care providers. OMH developed these no-cost trainings to give providers competencies to better treat an increasingly diverse population. The general training is available at [Think Cultural Health](#). OMH also has a no-cost, accredited maternal health care training available at [Think Cultural Health Education](#). Health Net does not sponsor these trainings or materials.

The Institute for Healthcare Improvement has free downloads to improve plain language communication with patients under the [Ask Me 3<sup>®</sup> program](#).

You can also access [Health Net's cultural competency training](#) for providers and PPG staff or contact Health Net's Health Equity Department for customized training to meet your needs.

Medi-Cal providers may have the completion of cultural competency training listed in the provider directory. The provider directory indicates a "Y" if the provider has completed two hours of cultural competency training within the last 24 months. Notify Health Net by email after completing the training at [PSOps@healthnet.com](mailto:PSOps@healthnet.com). Include



your practitioner's name, a certificate of completion, the National Provider Identifier (NPI), and a statement that you have completed the training.

Providers who would like information about interpreter services, cross-cultural communication, health literacy or to schedule a training, can contact [Health Net's Health Equity Department](#).

## Language Assistance Program and Cultural Competency

Provider Type: Hospitals

### Riverside and San Bernardino

Riverside and San Bernardino County Medi-Cal providers must receive interpreter services through [Molina Healthcare](#).

### All Other Counties

Health Net maintains an ongoing Language Assistance Program (LAP) to ensure members with limited English proficiency (LEP), limited reading skills, who are deaf or have hearing impairment, or who have diverse cultural and ethnic backgrounds have appropriate access to language assistance while accessing health care services. Health Net encourages providers to consider cultural competency courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to [OMH Think Cultural Health](#).

## Hospital Requirements

Health Net's participating hospitals are subject to requirements to provide language interpreter services for their patients pursuant to federal and state law. Health Net expects its participating hospitals to fully meet these obligations, notwithstanding Health Net's separate obligations to meet all requirements under the Health Care Language Assistance Regulations to provide language interpreter services for its members at all points of contact.

## Interpreter Services Requirements

Section 1557 of the Affordable Care Act (published as 45 CFR 92) provides new guidance on the use of bilingual staff that act as interpreters. The guidance is summarized below.

- Provide services to individuals with LEP and individuals with a hearing incapacity that are as effective as those provided to members without LEP.
- Providers may not request or require an individual with LEP to provide their own interpreter.

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- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not rely on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
  - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
  - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
  - Health Net members have the right to file a grievance with Health Net if their language needs are not met. Members also have the ability to file a discrimination complaint with the Office of Civil Rights if their language needs are not met.

Health Net has processes in place to ensure that members with LEP can obtain Health Net's assistance in arranging for the provision of timely interpreter services to the extent its participating hospitals are not required under state and federal law to provide a particular Health Care Language Assistance Regulations-required interpreter service.

Health Net monitors its participating hospitals for deficiencies in interpreter services and takes appropriate corrective action to address these deficiencies in the delivery of interpreter services to Health Net members.

Providers who would like to schedule trainings on topics such as cross-cultural communication, health literacy or accessing interpreter services should contact [Health Net's Health Equity Department](#).

For additional information, refer to [Health Net's Interpreter Services](#) or the [Health Industry Collaboration Effort \(HICE\): Provider Tools to Care for Diverse Populations \(PDF\)](#).

## Quality Improvement Program

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

This section contains general information on the Health Net Quality Improvement (QI) program.

Select any subject below:

- [Overview](#)
- [Health Net Quality Improvement Committees](#)
- [Participation in Public Reporting of Hospital Performance](#)
- [Quality Improvement HAC Program](#)
- [Quality Improvement Program](#)
- [Quality Improvement Program and Compliance and HEDIS](#)
- [Recognition for Quality Performance](#)
- [Quality of Care Issues](#)

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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; Health Homes Program (HHP), long term care (LTC), Long-Term Services and Supports (LTSS): Community Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) that 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.

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](#)).

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# 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

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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.**

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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 HNQC.

## 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 HNQC.

## Participation in Public Reporting of Hospital Performance

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

Health Net requires that all urban, acute care participating hospitals annually report safety and quality data results to at least one readily available consumer outlet, such as the Leapfrog Group Patient Safety Survey and the Centers for Medicare & Medicaid Services (CMS) [Hospital Compare website](#).

### WebMD's Hospital Advisor and publicly available hospital quality information

Health Net's Hospital Advisor Tool from WebMD offers members a wide range of details about the quality performance of individual hospitals, including rates of complications and mortality, the quantity of specific procedures performed at the facility, typical lengths of stay, average cost, and a variety of quality and patient safety indicators. The data is based on sources such as state reporting, survey results from The Leapfrog Group, CMS hospital quality indicators, and hospital patient satisfaction information. Health Net promotes member use of hospital quality data in mailed member letters and newsletters, online, by email, and in paid social media campaigns.

Similar data can be accessed by providers at the following publicly available websites:

- [Cal Hospital Compare](#)
- [The Centers for Medicare and Medicaid Services resource Care Compare](#)
- [The Leapfrog Group](#) (see below) for hospital ratings and Hospital Safety Grades

## The Leapfrog Group

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The Leapfrog Group is an organization founded to promote patient safety and improve quality of care. As a Leapfrog Partner, Health Net promotes participation in the Leapfrog hospital and ambulatory surgery center (ASC) surveys, which offer consumers key information about a facility's quality and safety performance with respect to established patient safety practices and progress toward national quality standards. Examples of hospital survey measures include:

- Computerized physician order entry.
- Intensive care unit physician staffing.
- Evidence-based hospital referral.
- Safe practices score based on National Quality Forum standards.

Participation in Leapfrog's surveys offers hospitals and ASCs the ability to assess their strengths and weaknesses in areas such as hospital-acquired infection scores and evidence-based care to address common acute conditions. In addition to making these survey findings publicly available, Leapfrog publishes a Hospital Safety Grade. This composite score assigns individual hospitals a letter grade to indicate hospital performance on patient safety according to an analysis of up to 27 quality measures. For more information, visit [The Leapfrog Group](#).

## Quality Improvement HAC Program

Provider Type: Hospitals

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

## Quality Improvement Program

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

Health Net's Quality Improvement (QI) program provides the infrastructure for all managed care products. The QI program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes and member and provider satisfaction. The purpose and goals of the QI program are to:

- Establish standards for both the quality and safety of clinical care and service, as well as monitor and evaluate the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.

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- Support Health Net's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

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

The Health Net QI program includes a written program description and an annually revised QI work plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement Committee (HNQIC), Health Net Community Solutions (HNCS) UM/QI Committee, and the Health Net board of directors approves and monitors the annual Health Net QI program and the QI work plan. The board of directors receives quarterly reports regarding medical affairs, QI, utilization management (UM), and pharmacy.



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# 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](http://www.calquality.org).
- The Leapfrog Group: Health Net works closely with The Leapfrog Group, purchases their data, and promotes their ratings and standards to network hospitals, members and the community.
- Cal Hospital Compare: Health Net collaborates with Cal Hospital Compare on a range of issues and contracts with them to obtain Poor Performer and Honor Roll reports and associated data files to inform hospital quality initiatives. .

## Recognition for Quality Performance

Provider Type: Physicians | Participating Physician Groups (PPG)

Participating physician groups (PPGs) and directly contracted primary care physicians (PCPs) participating in the Ambetter HMO and Ambetter PPO may participate in a financial incentive program for improving quality of care as quantified by Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

Incentives will be based on the following 4 HEDIS measures for care gap closure:

| CODE | HEDIS MEASURE DESCRIPTION       | SUB-MEASURE |
|------|---------------------------------|-------------|
| CBP  | Controlling High Blood Pressure |             |

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| CODE | HEDIS MEASURE DESCRIPTION                         | SUB-MEASURE            |
|------|---|------------------------|
| HBD  | Hemoglobin A1c Control for Patients with Diabetes | HbA1c Control (< 8.0%) |
| COL  | Colorectal Cancer Screening                       |                        |
| CIS  | Childhood immunization status                     | Combination 10         |

Incentives are calculated and paid out in November of the calendar year and a final payment for the full calendar year by the following August. The incentive program is not part of the compensation under the Health Net Provider Participation Agreement (PPA); it is supplemental compensation in addition to, but separate from, contracting rates. As such, Health Net reserves the right to alter the incentive program on an annual basis or to terminate it at any time by notifying the provider in writing of such termination.

Providers may contact their provider relations liaison or your provider network director for additional information about the incentive program.

## Quality of Care Issues

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

Potential quality of care issues are reviewed by a Health Net medical director and, based on findings, are given a severity level and, as indicated, submitted to the peer review committee (PRC) for appropriate resolution. 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](#)
- [Investigational and Experimental Treatment](#)
- [Lab and X-Ray Referrals](#)

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

A physician may decide that it is necessary for the member to receive treatment from another physician or specialist and should refer the member to a PPO in-network physician when possible. No prior authorization is required. If the member is referred to an out-of-network provider, the member's benefits are reduced and a higher out-of-pocket cost is incurred. To determine if the specialist is a PPO in-network physician, contact the [Health Net Provider Services Department](#) or consult the [Health Net website](#).

## Identifying PPO Participating Providers

The Health Net provider directory lists the network physicians, hospitals and ancillary providers that are participating in the PPO health plans. When referring members to other providers, use the directory or consult the [Health Net website](#).

## Referring Members to Out-of-Network Providers

A PPO participating provider is responsible for referring members to other Health Net participating providers unless, in the provider's professional judgment, the member's needs require a referral to an out-of-network provider. In this case, the member must be notified that the proposed referred provider is not a Health Net participating provider.

The member is responsible for the scheduled copayment and deductible, plus any amounts that exceed Health Net's maximum out-of-network reimbursement. Additionally, the member may be required to pay the bill in full to the provider and request reimbursement from Health Net.

When a referral is made to a participating provider, the in-network benefits are applicable, resulting in a lower out-of-pocket expense for the member.

## 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.

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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](http://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](http://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](http://www.dmhc.ca.gov) and search for IMR applications.

## Lab and X-Ray Referrals

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

Routine lab and X-ray services do not require prior authorization. High-tech radiology services, such as CTs, MRIs, MRAs, PETs, and SPECTs, require prior authorization; refer to the [PPO Prior Authorization Requirements List](#) for additional information. Participating physicians are required to refer members to Health Net PPO participating providers for lab and X-ray services, if available in their service area. Refer to the ancillary provider section of the provider directory, contact the [Health Net Provider Services Department](#) or consult the [Health Net website](#).

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## Third-Party Liability

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

This section contains general information on third-party liability responsibilities.

Select any subject below:

- [Coverage Explanation](#)

## Coverage Explanation

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

If a subscriber or member is injured through an act or omission of another person, the [participating provider](#) must provide benefits in accordance with the Evidence of Coverage (EOC) or [Certificate of Insurance \(COI\)](#). If the injured member is entitled to recovery, the plan and the participating provider rendering services to the member are entitled to recover and retain the value of the services provided from any amounts received by the member from third-party sources.

When the plan pays a claim with an injury or trauma diagnosis code that may be related to a motor vehicle accident, employment or possible other third-party liability, the plan may use an outside vendor, the Rawlings Company, to investigate for determination of other coverage liability. Rawlings' expertise and automated system capabilities are used to identify claims where a third party may be responsible for payment. Rawlings may directly correspond with providers requesting refunds when another liability coverage is determined to be primary. If a provider receives a refund request letter from the Rawlings Company that includes the primary coverage insurance information in the event that the provider has not already been provided the other coverage information by the member or billed the primary carrier, the provider is expected to bill the other coverage and refund the plan, via the Rawlings Company, within a reasonable time period. Failure to comply with timely filing guidelines when overpayment situations are the result of another carrier being responsible does not release the participating provider from liability.

Reimbursement to the plan or the participating provider under this lien is based on the value of the services the member receives and the costs of perfecting the lien. The value of the services depends on how the participating provider was paid and the lien amount is determined as permitted by law. Unless the money that the member receives comes from a workers' compensation claim, the following applies:

- The amount of the reimbursement that the member owes the plan or the participating provider is reduced by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines that the member was responsible for some portion of the member's injuries.
  - For plans subject to state law, when the member is represented by an attorney: the lien will be the lesser of a *pro rata* reduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
  - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

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## 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 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.

It is the participating provider's responsibility to act reasonably in pursuing a lien.

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## Member Responsibility

An injured member entitled to recovery is required to:

- Inform the plan and participating providers of the name and address of the third party, if known, the name and address of the member's attorney, if using an attorney, and describe how the injuries were caused.
- Complete any paperwork that the plan or the participating providers may reasonably require to assist in enforcing the lien.
- Promptly respond to inquiries from lien holders about the status of the case and any settlement discussions.
- Notify lien holders immediately upon the member or the member's attorney receiving any money from third parties or their insurance companies.
- Hold any money that the member or the member's attorney receives from third parties or their insurance companies in trust, and reimburse the plan and the participating providers for the amount of the lien as soon as the member is paid by the third party.

## Utilization Management

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

This section describes Health Net's utilization management program and processes.

Select any subject below:

- [Overview](#)
- [Clinical Criteria for Medical Management Decision Making](#)
- [Continuity of Care](#)
- [Economic Profiling](#)
- [Hospital Discharge Planning](#)
- [Medical Data Management System](#)
- [Non-Delegated Medical Management](#)
- [Notification of Hospital Admissions](#)
- [Utilization Management Goal](#)

## 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.

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Refer to [definition of medical necessity](#) or [definition of investigational services](#) for additional information.

## Care Management

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

This section contains general information on care management.

Select any subject below:

- [Overview](#)
- [Care Manager](#)
- [NICU Levels of Care Criteria](#)
- [Palliative Care Services](#)

## 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.

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- **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.

## Care Manager

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

The care manager acts in support of providers, members and families to improve health, assist with health care decisions and assist in obtaining other services that can improve the member's health and functional status.

The care manager is responsible for monitoring and managing effective and efficient use of health care services for Health Net members by identifying, coordinating, and managing members who require care management.

The care manager identifies candidates for care management from either internal or external referral sources. High-risk and high-volume cases are managed for the duration of the member's health care needs or until a care plan is no longer required.

## NICU Levels of Care Criteria

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

Health Net's [neonatal intensive care unit \(NICU\) levels of care criteria \(PDF\)](#) is used by delegated participating physician groups (PPGs), contracting vendors and concurrent review staff when assessing, documenting and authorizing NICU care. These criteria apply to the HMO, PPO and Point of Service (POS) lines of business.

Health Net contracts with Alere care management services to provide NICU services for those PPGs who participate in the program. Alere provides onsite case management services for newborns who require admission into the NICU. Health Net's concurrent review department continues oversight and works collaboratively with Alere staff to ensure ongoing delivery of appropriate care, services and safe discharges when the infant is ready to transition from the hospital setting.

## Palliative Care Services

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

Eligible members (including Dual Special Needs Plans (D-SNPs)) at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or liver disease. Life expectancy is 12

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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)

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- 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.





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# 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 policies 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) (does not apply to HSP)| Hospitals

Health Net provides for continuity of care (COC) for new and existing members due to termination of prior coverage and any health plan withdrawn from any portion of the market for a currently enrolled Health Net member. Health Net members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months.

A current member may also request COC to complete care with a departing Health Net provider after that provider leaves Health Net’s network. Covered services are provided for the period of time necessary to complete a course of treatment and to arrange for safe transition of care to another provider. Health Net makes the decision in consultation with the member and the terminated provider or nonparticipating provider, and consistent with good professional practice.

## Continuity of Care

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Member requests for COC assistance must meet certain criteria:

- There are no documented quality-of-care issues, or state or federal exclusion requirements where Health Net has determined the provider is ineligible to continue providing services to Health Net members.
- Compensated rates and methods of payment are the same as those currently used by Health Net or the participating physician group (PPG) unless a letter of agreement or letter of understanding is executed.
- Copayments, deductibles or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same the member would pay if receiving care from a provider currently contracting with Health Net.

## Types of clinical criteria where a member may be eligible for COC

- Acute condition – a sudden onset of symptoms due to an illness, injury, or other medical problem.
- Serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder, not to exceed 12 months from the member's effective date of coverage.
- Pregnancy – for the duration of the pregnancy and the immediate postpartum period.
  - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri- or post-partum, or that arises during pregnancy, in the peri- or post-partum period, up to one year after delivery.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. COC applies for the duration for the terminal illness.
- Newborn care – birth to 36 months, not to exceed 12 months from the member's effective date of coverage under the plan.
- Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
- Behavioral health conditions – all acute, serious or chronic mental health conditions, including treatment for children diagnosed with autism spectrum disorder (ASD). These services include applied behavioral analysis (ABA) – for up to 12 months.

## Exceptions

Some of the circumstances where COC is not available are:

- Services that are not a covered benefit of the plan.
- Out-of-network provider does not agree to Health Net's utilization management (UM) policies and payment rates.
- Provider type or service is for durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

## Requesting Continuity of Care

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New and existing members, their authorized representatives on file with Health Net, or their providers may request COC directly from Health Net. Refer to the [Health Net Member Services Department](#) for assistance.

Health Net reviews and completes COC requests within five business days after receipt of the request. When additional clinical information is necessary to make a decision, the COC request can be pended for an additional 45 days. The pend letter for the required information is generated and faxed to the requested provider. A hard copy will follow by mail to the provider and the member.

If there is an imminent and serious threat to the member's health, requests are completed within three calendar days.

Upon completion of the COC review, the provider and the member will be notified of the decision within 24 hours of the decision.

**Applies to EPO and PPO members only:** Health Net accepts and approves retroactive requests for COC that meet all requirements. The services must have occurred after the member's enrollment in the plan and Health Net must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the plan.

Out-of-network providers cannot refer the member to another out-of-network provider without authorization from Health Net or a delegated PPG.

## PPG Process

Health Net forwards the COC request to the delegated PPG's UM department if the PPG termed the requested provider. The delegated PPG:

- Works with the out-of-network provider to secure a care plan for the member
- Makes the decision whether to extend the COC services, or to redirect the services in-network.
- Works with the out-of-network provider to make sure they are willing to work with the PPG and Health Net.

## Economic Profiling

Provider Type: Physicians | Participating Physician Groups (PPG)

Economic profiling is defined as any evaluation of a provider or participating physician group (PPG) based in whole or in part on the economic costs or use of services associated with medical care provided or authorized by the provider or PPG.

To the extent that a PPG maintains economic profiles of its individual providers, it must provide on request a copy of the individual economic profiling information to the individual providers who are profiled. This information must be provided on request until 60 days after the contract between the PPG and provider terminates.



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# Hospital and Inpatient Facility Discharge Planning

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

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The [Transitional Care Services](#) program is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Members have the right to:

- Be informed of continuing health care requirements following discharge from the hospital or inpatient facility.
- Be informed that, if the member authorizes, a friend or family member may be provided information about the member's continuing health care requirements following discharge from the hospital or inpatient facility.
- Actively participate in decisions regarding medical care. To the extent permitted by law, participation includes the right to refuse treatment.
- Appropriate pain assessment and treatment.

## Electronic medical records or administrative system

In accordance with the Provider Participating Agreement (PPA) and Federal regulation [42 CFR 482.24 section \(d\)](#), hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

- [Los Angeles Network for Enhanced Services \(LANES\)](#)
- [Manifest MedEx](#)
- [SacValley MedShare](#)
- [San Diego Health Connect](#)
- [Applied Research Works, Inc.](#)
- [Health Gorilla, Inc.](#)
- [Long Health, Inc.](#)

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- [Orange County Partners in Health-Health Information Exchange \(OCPH-HIE\)](#)
- [Serving Communities Health Information Organization \(SCHIO\)](#)

## Medical Data Management System

Provider Type: Physicians | Participating Physician Groups (PPG)

The Health Net utilization management (UM) program is supported by Unity, Health Net's medical management system. Unity provides an integrated database for Health Net UM activities. The system supports business management, drives regulatory compliance, and optimizes automation. It also provides medical management with the data to identify trends or patterns.

Health Net reviews encounter data to determine whether membership is accurately represented, to confirm that the data is submitted within contractual time frames and is within normative rates; for example, if an encounter rate is greater than 10 percent of a normative standard or the services provided per member per year is below six encounters. Health Net discusses actions for improved utilization management with the participating physician group (PPG).

## Non-Delegated Medical Management

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

Health Net does not delegate performance of the utilization management (UM) function to fee-for-service (FFS) [participating providers](#). Health Net performs UM, quality improvement (QI) and care management functions.

Health Net uses InterQual criteria, Medicare guidelines, Hayes Medical Technology Directory®, Health Net medical policies, and MHN level-of-care criteria as the basis for making utilization decisions. Case-specific determinations of medical necessity are based on the needs of the individual member and the characteristics of the local network. Appropriate providers are involved in the adoption, development, updating (as needed), and annual review of medical policies and criteria. Delegated participating physician groups (PPGs) and MHN are required to use approved scientifically based criteria. Health Net national medical policy statements are currently available on the [Health Net provider portal](#). Medical policy statements and other clinical criteria, such as InterQual and Hayes Technology Assessments, are available to all Health Net PPGs upon request by calling the [Health Net Provider Services Center](#).

## Non-Delegated Concurrent Review

Health Net's concurrent review staff perform clinical reviews when UM functions are not delegated. The objective of concurrent review is to review clinical information for medical necessity during a member's hospital confinement, coordinate discharge plans, and screen for quality of care concerns.

The hospital is required to notify Health Net's [Hospital Notification Unit](#) within 24 hours of admission or one business day when an admission occurs on a weekend, whenever a Health Net member is admitted. Failure to notify according to the requirements in the Provider Participation Agreement (PPA) may result in a denial of



payment. The first review occurs within 24 hours or one business day of admission and is performed either on-site or over the telephone by a Health Net concurrent review nurse.

Use of standardized review criteria is required to ensure consistency of decision-making. Health Net's concurrent review nurses use InterQual guidelines to determine medical necessity of the inpatient stay. Review of the medical records is performed as required on an ongoing basis.

If, based on available information, an acute level of care is determined to be no longer necessary, Health Net's concurrent review nurse reviews the clinical information with a Health Net regional medical director. The Health Net concurrent review nurse also notifies the Hospital Utilization Review Department that the continued stay is in question. Discussion with the Health Net regional medical director focuses on alternate levels of care and discharge plans.

If the Health Net regional medical director determines that based on available medical information the member is ready for discharge, the attending physician is contacted to discuss alternatives. If the attending physician agrees with the Health Net regional medical director, the member is discharged to home or transferred to an appropriate, lower level of care. Concurrent review staff work with the PPG staff to monitor the member's care, and coordinate transfers and any needed post-discharge services.

If the attending physician and the Health Net regional medical director disagree, Health Net may issue a denial letter to the hospital, with copies to the attending physician, the PPG or the member. A denial letter contains the basis for the denial and information on the appeals and grievance process, as required by state and federal law. For Medicare Advantage (MA) members, Health Net follows the Centers for Medicare and Medicaid Services (CMS) guidelines when issuing a denial letter.

## Non-Delegated Prospective Review

Under the terms of a member's coverage with Health Net, Health Net must provide pre-service authorization for elective inpatient services and selected outpatient procedures for PPO providers and participating fee-for-service (FFS) HMO providers. This also applies to contracting providers rendering services under Tier 2 Point of Service (POS) benefits. Following review by a Health Net medical director, authorization is approved or denied and communicated in writing to the PPG or requesting physician and the member.

When requesting a pre-service authorization for elective services or selected outpatient procedures, documentation by the referring participating physician must include:

- Prior written authorization request for specified outpatient services, specifying:
  - Services requested and number of visits
  - Information about previously attempted but unsuccessful treatments
  - Sufficient clinical information to establish medical necessity

Providers may use the appropriate forms below or refer to the Prior Authorization topic for additional information.

[Inpatient California Health Net Commercial Prior Authorization \(PDF\)](#)

[Outpatient California Health Net Commercial Prior Authorization \(PDF\)](#)

[Inpatient California Health Net Medicare Authorization Form \(PDF\)](#)

[Outpatient California Health Net Medicare Authorization Form \(PDF\)](#)



- Prior written authorization request for hospitalization which is submitted by the PCP or specialist must include:
  - Necessity of admission
  - Pre-admission work-up
  - Number of medically necessary inpatient days
- If admission is denied, the requesting physician and member is sent the following information:
  - Written rationale for denial with the specific reason delineated
  - Information as to how to appeal Health Net's determination
  - Suggestions for alternative treatment

Health Net does not pay claims without a Health Net authorization number. Authorization and claims dates must correspond, and the service type must match before payment can be rendered. If the dates of service change after the authorization number has been issued, the provider is required to notify Health Net. When a claim is received without a Health Net authorization number or the dates and services do not match the recorded authorization, further investigation is conducted by the Medical Review Unit (MRU). MRU examines hospital records and authorization notes in Unity to reconcile the discrepancies.

## Non-Delegated Retrospective Review

Retrospective review is the review of medical services after care has been rendered. Retrospective review involves an evaluation of services that fall outside Health Net's established guidelines for coverage or require a medical necessity or benefit determination to authorize a request for payment of a claim.

## Notification of Hospital Admissions

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

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

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

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

Inpatient admissions may be reported by fax, 24 hours a day, seven days a week. A Health Net representative verifies eligibility, obtains information regarding the admission, and, if applicable, provides a tracking number for the claim.

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

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).
- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number.
- For obstetrical (OB) delivery admissions, include newborn sex, weight, apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

On receipt of admission notification, authorized services are entered into the Health Net's notification system and a tracking number is created and provided to the reporting party. The tracking number is also transferred electronically to the Health Net claims processing system.

The tracking number is not an authorization that services are covered under a member's benefit plan.

Telephone coverage is provided 24 hours a day, seven days a week for non-participating facilities reporting post-stabilization. Note: plans for which Department of Managed Health Care (DMHC) provides oversight (HMO, POS, Elect, Elect Open Access) have telephone coverage 24 hours a day, seven days a week for non-participating facility requests for prior authorization of services for patients deemed stabilized.

Providers can access the [Transitions of Care Management \(TRC\) Worksheet](#) to:

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

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

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

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

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

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|                     |  |
|---------------------|--|
| 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     | <p>Must notify the D-SNP member’s MCP within 48 hours after any SNF admission.</p> <p>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</p> |

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

## 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

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# Contacts in Alphabetical Order

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## A

- [AcariaHealth](#)
- [Access to Interpreter Services](#)
- [American Specialty Health Plans](#)
- [Animas Diabetes Care, LLC](#)
- [Apria Healthcare, Inc](#)
- [ATG Rehab Specialists, Inc](#)

## B

[Behavioral Health Provider Services](#)

## C

- [Case Management Department](#)
- [Centene Vision Services](#)
- [Connect Hearing, Inc](#)
- [Coram](#)
- [Custom Rehab Network](#)

## D

[Department of Insurance](#)

## E

- [Electronic Claims Clearinghouse Information](#)
- [EviCore Healthcare](#)
- [Evolent Specialty Services, Inc.](#)



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F

G

H

- Health Net Care Management Department
- Health Net Credentialing Department
- Health Net Decision Power Referral Fax
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Elect Claims
- Health Net Fraud Hotline
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Mail Order Prescription Drug Program
- Health Net Member Appeals and Grievances Department
- Health Net Member Services Department
- Health Net Provider Communications Department
- Health Net PPO Claims Submission
- Health Net Prior Authorization Department
- Health Net Program Accreditation Department
- Health Net Provider Services Center
- Health Net Quality Improvement Department
- Health Net's Regional Medical Directors
- Health Net Transplant Care Manager
- Health Net Wellness and Prevention Department
- Hoveround, Inc

I

J

K

[Kick It California](#)



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## L

- [LabCorp](#)
- [Linkia, LLC](#)

## M

- [MiniMed Distribution Corp, Inc](#)
- [Modivcare](#)

## N

- [National Seating and Mobility](#)
- [Nurse Advice Line](#)

## O

## P

- [Peer-to-Peer Review Request Line](#)
- [Pharmacy Services](#)
- [Provider Disputes and Appeals - Commercial](#)
- [Provider Network Management Department](#)
- [Pumping Essentials](#)

## Q

[Quest Diagnostics](#)

## R

[Roche](#)



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S

T

- [Transitional Care Services](#)
- [Transplant Team](#)
- [TurningPoint Healthcare Solutions, LLC](#)

U

V

W

X

Y

Z



## Glossary

- AIDS
- Appeal
- Certificate of Insurance (COI)
- Clean Claim
- Clinical Trials
- Complaint
- Emergency
- Evidence of Coverage (EOC)
- Facility Site Review
- Grievance
- Hospice Services
- Inquiry
- Investigational Services
- Medical Necessity
- Medical Waste Management Materials
- Medical Information
- Member Handbook
- Not Medically Necessary
- Offshore
- Opt Out Provider
- Participating Provider
- Primary Care Physician (PCP)
- Psychiatric Emergency Medical Condition
- Residential Treatment
- Telehealth
- Schedule of Benefits or Summary of Benefits (SOB)
- Serious Illness
- Subcontractor
- Unclean Claim



# PDF Forms and References in Alphabetical Order

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## #

## A

- [AAP Recommendations for the Preventive Pediatric Health Care \(PDF\)](#)
- [Adult AIDS/HIV Confidential Case Report \(PDF\)](#)
- [After-Hours Sample Script - Chinese \(PDF\)](#)
- [After-Hours Sample Script - English \(PDF\)](#)
- [After-Hours Sample Script - Spanish \(PDF\)](#)
- [Autoclave Log \(PDF\)](#)

## B

[Bariatric Surgery Performance Center \(PDF\)](#)

## C

- [Care Management Referral Form \(PDF\)](#)
- [Certification for Contracts Grants, loans, and Cooperative Agreements \(PDF\)](#)
- [Clinical Payment Policy CP.MP.152 - Measurement of Serum 1 25-dihydroxyvitamin D \(PDF\)](#)
- [Clinical Payment Policy CP.MP.153 - Helicobacter Pylori Serology Testing \(PDF\)](#)
- [Clinical Payment Policy CP.MP.154 - Thyroid Hormones and Insulin Testing in Pediatrics \(PDF\)s](#)
- [Clinical Payment Policy, CCP.MP.155 - EEG in the Evaluation of Headache \(PDF\)](#)
- [Clinical Payment Policy CP.MP.156 - Cardiac Biomarker Testing for Acute Myocardial In farction \(PDF\)](#)
- [Clinical Payment Policy CP.MP.157 - 25-hydroxyvitamin D Testing in Children and Adolescents \(PDF\)](#)
- [Clinical Payment Policy CP.MP.38 - Ultrasound in Pregnancy Cold Sterilization Log \(PDF\)](#)
- [Confidential Morbidity Report \(PDF\)](#)



## D

- [Decision Power Referral Fax Form \(PDF\)](#)
- [Diagnostic Evaluation/Assessment Form \(PDF\)](#)
- [Diagnostic Procedures Requiring Prior Authorization for Health Net of California \(PDF\)](#)
- [Directory Removal for At-Risk Providers Form \(PDF\)](#)
- [Disclosure of Lobbying Activities Form and Disclosure Form Instructions \(PDF\)](#)
- [Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Coding Policies \(PDF\)](#)

## E

- [Edinburgh Perinatal/Postnatal Depression Scale \(EPDS\) Questionnaire \(PDF\)](#)
- [Eligibility Report Field Descriptions \(PDF\)](#)

## F

## G

## H

[Hepatitis B Vaccination Declination \(PDF\)](#)

## I

- [ICD-10-CM Codes for Abortion-Related Services \(PDF\)](#)
- [Identification card \(Elect Open Access\) \(PDF\)](#)
- [Identification card \(Ambetter PPO\) \(PDF\)](#)
- [Identification card \(PPO\) \(PDF\)](#)
- [Identification card \(Select POS\) \(PDF\)](#)
- [Individual Family Plan member eligibility status displayed on the secure provider portal \(PDF\)](#)
- [Industry Collaboration Effort \(ICE\): Provider Tools to Care for Diverse Populations \(PDF\)](#)
- [Inpatient California Health Net Commercial Prior Authorization \(PDF\)](#)
- [Interpreter Service Quick Reference Card \(PDF\)](#)





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J

K

L

[Language Identification Poster \(PDF\)](#)

M

- [Medical Record - Adult Health Maintenance Checklist With Standards \(PDF\)](#)
- [Medical Record - Advance Directive Labels \(PDF\)](#)
- [Medical Record - Audiometric Screening \(PDF\)](#)
- [Medical Record - History Spanish \(PDF\)](#)
- [Medical Record - Medication and Chronic Problem Summary \(PDF\)](#)
- [Medical Record - Signature Page \(PDF\)](#)
- [Medical-Behavioral Comanagement-Coordination of Care Form \(PDF\)](#)

N

- [NICU Level of Care Criteria \(PDF\)](#)
- [Nondiscrimination Notice and Tagline \(PDF\)](#)

O

- [Offshore Subcontracting Attestation: Participating Provider \(PDF\)](#)
- [Outpatient California Health Net Commercial Prior Authorization \(PDF\)](#)

P

- [Palliative Care Providers \(contracted\)](#)
- [Physical or Speech Therapy \(PDF\)](#)
- [Potential Quality Issue Referral Form \(PDF\)](#)
- [Prescription Drug Prior Authorization or Step Therapy Exception Form \(PDF\)](#)
- [Prostate Cancer Treatment Information Sign \(PDF\)](#)
- [Provider Dispute Resolution Request - Commercial and Medi-Cal \(PDF\)](#)
- [Provider Dispute Resolution Request - IFP \(PDF\)](#)

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## Q

[Quick Reference Guide \(PDF\)](#)

## R

- [Reportable Diseases \(PDF\)](#)
- [Request for Confidential Communication Form \(PDF\)](#)

## S

## T

- [Transition of Care Management Worksheet](#)
- [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 \(PDF\)](#)

## V

[Verifying Eligibility \(Individual and Family Plans\) \(PDF\)](#)



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W

X

Y

Z



















## 非營業時間腳本範例

醫師和醫療團體可以使用下列腳本之一做為範本，確保即使在非營業時間或診所休診時間 Health Net 會員仍可及時取得醫療照護。

重要：在非營業時間提供有效率的電話服務可確保會員來電時能在 30 秒內接通電話服務人員或答錄機服務。

### I. 電話服務人員接聽電話 (例如代客接聽電話服務或集中檢傷分類服務)：

如果來電會員認為自己發生醫療緊急情況，請告訴來電會員先掛斷電話，然後馬上撥 911 或前往最近的急診室 / 醫療機構。

如果來電會員認為情況緊急，或表示需要和醫師通話，請採取以下一項或多項動作，協助聯絡醫師：

- 暫時保留來電會員的電話，然後把來電會員轉接給待命醫師
- 留下來電會員的電話號碼，並告訴來電會員，醫師會在 30 分鐘內回電 (立即傳送訊息給醫師)
- 把待命醫師的傳呼號碼給來電會員，並告訴來電會員，醫師會在 30 分鐘內回會員電話；或指示來電會員前往最近的緊急照護中心
- 如果來電會員表示需要口譯服務，請使用口譯服務以協助聯絡

#### 範例：

您好，這裡是<姓氏>醫師的<代客接聽電話服務 / 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請別掛斷，我會幫您轉接電話。

您好，這裡是<姓氏>醫師的<代客接聽電話服務 / 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，<姓氏>醫師可以協助您。請<傳呼 / 撥打> <電話號碼> 聯絡醫師。您應該會在 30 分鐘內接到回電。

### II. 答錄機接聽電話：

您好，這裡是 <輸入醫師姓名 / 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話 (選擇適當的選項)：

- 請稍候，我們會為您轉接<姓氏>醫師。
- 您可以撥 <電話號碼> 直接聯絡待命醫師。
- 請按 <號碼>，就可以轉接我們的緊急照護中心。我們緊急照護中心的地址是 <緊急照護中心地址> (應針對該地點提供適當的語言選項。)
- 請按 <號碼>，就可以傳呼待命醫師。您應該會在 30 分鐘內接到回電。

#### 範例：

您好，這裡是 <醫師 / 醫療團體名稱> 的<姓氏>醫師。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請留下您的姓名、電話號碼，以及來電的原因，您應該會在 30 分鐘內接到回電。

您好，這裡是 <醫師姓名 / 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，您可以撥 <電話號碼> 或按 <號碼> 進行傳呼，就可以直接聯絡待命醫師。您應該會在 30 分鐘內接到回電。



## AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

### I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within 30 minutes (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within 30 minutes, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

#### Examples:

*Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.*

*Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>. You may expect a call back within 30 minutes.*

### II. CALLS ANSWERED BY AN ANSWERING MACHINE:

*Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):*

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within 30 minutes*

#### Examples:

*Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within 30 minutes.*

*Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within 30 minutes.*



## EJEMPLO DE TEXTO PARA USAR FUERA DEL HORARIO DE ATENCIÓN

Los médicos y grupos médicos pueden utilizar uno de los siguientes textos como plantilla para garantizar que los afiliados a Health Net tengan acceso a una atención médica oportuna fuera del horario de atención o cuando sus consultorios están cerrados.

**IMPORTANTE:** Un servicio telefónico eficaz fuera del horario de atención garantiza que las personas que llaman puedan comunicarse con una voz en vivo o un contestador automático dentro de los 30 segundos.

### **I. LLAMADAS RESPONDIDAS POR UNA VOZ EN VIVO (como un servicio de mensajes telefónicos o un servicio centralizado de clasificación según las prioridades de atención):**

Si la persona que llama cree que está teniendo una emergencia médica, indíquele que cuelgue y que llame al 911 de inmediato, o bien, que se dirija a la sala de emergencias/al centro médico más cercano.

Si la persona que llama cree que la situación es de urgencia o indica que necesita hablar con un médico, póngala en contacto con el médico siguiendo uno o más de los pasos a continuación:

- Déjela en espera por un momento y luego comuníquela con el médico de guardia
- Solicítele el número de teléfono e indíquele que un médico le devolverá la llamada dentro de los 30 minutos (envíe un mensaje al médico de inmediato)
- Proporciónale el número del buscapersonas del médico de guardia e indíquele que el médico llamará al afiliado dentro de los 30 minutos, o bien, diríjala al centro de atención de urgencia más cercano
- Si una persona que llama indica que necesita servicios de intérprete, póngala en contacto con quien pueda brindarle dichos servicios

#### **Ejemplos:**

*Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, permanezca en línea mientras le comunico.*

*Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, el Dr./la Dra. <Apellido> puede ayudarle. Por favor, <llámelo/la> al <número de teléfono>. Calcule que se le devolverá la llamada dentro de los 30 minutos.*

### **II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMÁTICO:**

*Hola, usted se ha comunicado con <insertar el nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia (seleccione la opción correspondiente):*

- *Por favor, espere un momento mientras le comunico con el Dr./la Dra. <Apellido>*
- *Usted puede comunicarse directamente con el médico de guardia llamando al <número de teléfono>*
- *Oprima <número> para transferir la llamada a nuestro centro de atención de urgencia, que está ubicado en <dirección del centro de atención de urgencia> (Se deben proporcionar las opciones de idioma correspondientes a la ubicación.)*
- *Oprima <número> para llamar al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.*

#### **Ejemplos:**

*Hola, usted se ha comunicado con <Nombre del Médico/Group Médico> para el Dr./la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, deje un mensaje con su nombre, su número de teléfono y el motivo por el que llama, y calcule que se le devolverá la llamada dentro de los 30 minutos.*

*Hola, usted se ha comunicado con <Nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, puede comunicarse directamente con éste llamando al <número de teléfono> u oprimiendo <número> para acceder al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.*











**Health Net\* of California, Inc. Bariatric Surgery Performance Centers**
**Northern California**

| <b>Surgeon name and group</b>                        | <b>Physician address</b>   | <b>Phone number</b>              | <b>Center name</b>                        | <b>Center address</b>  |
|--|--|----------------------------------|---|--|
| Ali, M.D., Mohamed                                   | 2221 Stockton Blvd.,<br>Ste. E<br>Sacramento, CA 95817               | (916) 734-2680                   | U.C. Davis<br>Medical Center <sup>1</sup> | 2315 Stockton Blvd.<br>Sacramento, CA<br>95817                 |
| Azagury, M.D., Dan                                   | 300 Pasteur Dr.<br>Stanford, CA 94305                                | (650) 725-9777                   | Stanford<br>Hospital and<br>Clinic        | 300 Pasteur Dr.<br>Stanford, CA 94305                          |
| Boone, M.D., Keith<br>Valley Surgical<br>Specialists | 205 East River Park<br>Circle, Ste. 460<br>Fresno, CA 93710          | (559) 261-4500                   | Fresno Heart<br>and Surgical<br>Hospital  | 15 East Audubon Rd.<br>Fresno, CA 93720                        |
| Carter, M.D.,<br>Jonathan                            | 400 Parnassus Ave.,<br>2nd Floor<br>San Francisco, CA 94143-<br>0338 | (415) 353-2161                   | U.C. San<br>Francisco<br>Medical Center   | 505 Parnassus Ave.,<br>4th Floor<br>San Francisco, CA<br>94143 |
| Coirin, M.D., Antonio                                | 1329 Spanos Court,<br>Ste. B4<br>Modesto, CA 95355                   | (209) 300-7947                   | Memorial<br>Medical Center                | 1700 Coffee Rd.<br>Modesto, CA 95355                           |
| Eslami, M.D., Afshin                                 | 1737 Creekside Dr.<br>Folsom, CA 95630                               | (916) 932-0315                   | Methodist<br>Hospital                     | 7500 Hospital Dr.<br>Sacramento, CA<br>95823                   |
| Esquivel, M.D.,<br>Micaela                           | 300 Pasteur Dr., H3680<br>Stanford, CA 94305                         | (408) 396-7669                   | Stanford<br>Hospital and<br>Clinic        | 300 Pasteur Dr.<br>Stanford, CA 94305                          |
| Feng, M.D., John J. <sup>2</sup>                     | 790 El Camino Real<br>Palo Alto, CA 94301                            | (650) 853-6600<br>(650) 596-4120 | El Camino<br>Hospital                     | 2500 Grant Rd.<br>Mountain View, CA<br>94040                   |
|  |  |                                  | Mills Peninsula                           | 1783 El Camino Real<br>Burlingame, CA 94010                    |
| Higa, M.D., Kelvin<br>Valley Surgical<br>Specialists | 205 East River Park<br>Circle, Ste. 460<br>Fresno, CA 93710          | (559) 261-4500                   | Fresno Heart<br>and Surgical<br>Hospital  | 15 East Audubon Rd.<br>Fresno, CA 93720                        |

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**Health Net of California, Inc. Bariatric Surgery Performance Centers**
**Northern California, continued**

| <b>Surgeon name and group</b>          | <b>Physician address</b>                                    | <b>Phone number</b> | <b>Center name</b>              | <b>Center address</b>                                       |
|--|---|---------------------|---------------------------------|---|
| Khalil, M.D., Beeman <sup>2</sup>      | 795 El Camino Real<br>Palo Alto, CA 94301                   | (650) 853-5340      | El Camino Hospital              | 2500 Grant Rd.<br>Mountain View, CA 94040                   |
|  | 3200 Kearney St.<br>Fremont, CA 94538                       | (510) 490-1222      |                                 |   |
| Kim, M.D., Teresa <sup>2</sup>         | 365 Hawthorne Ave.,<br>Ste. 101<br>Oakland, CA 94609        | (510) 465-5523      | Alta Bates Summit               | 350 Hawthorne Ave.<br>Oakland, CA 94609                     |
| Legha, M.D., Prithvi <sup>2</sup>      | 701 E. El Camino Real<br>Mountain View, CA 94040            | (650) 404-8400      | El Camino Hospital              | 2500 Grant Rd.<br>Mountain View, CA 94040                   |
| Patching, M.D., Steven C. <sup>2</sup> | 800 Howe Ave, Ste. 300<br>Sacramento, CA 95825              | (916) 568-5564      | Sutter General Hospital         | 2801 L St.<br>Sacramento, CA 95816                          |
| Posselt, M.D., Andrew                  | 400 Parnassus Ave.,<br>2nd Floor<br>San Francisco, CA 94143 | (415) 353-2161      | UCSF Medical Center             | 505 Parnassus Ave.,<br>4th Floor<br>San Francisco, CA 94143 |
| Reddy, M.D., Subhash <sup>2</sup>      | 3 Medical Plaza, Ste. 200<br>Roseville, CA 95661            | (916) 773-8750      | Sutter Roseville Medical Center | 1 Medical Plaza<br>Roseville, CA 95661                      |
| Rogers, M.D., Stanley                  | 400 Parnassus Ave.,<br>2nd Floor<br>San Francisco, CA 94143 | (415) 353-2161      | UCSF Medical Center             | 505 Parnassus Ave.,<br>4th Floor<br>San Francisco, CA 94143 |
| Shadle, M.D., Benjamin D.              | 3 Medical Plaza, Ste. 200<br>Roseville, CA 95661            | (916) 773-8750      | Sutter Roseville Medical Center | 1 Medical Plaza<br>Roseville, CA 95661                      |
|  | 400 Plumas Blvd.,<br>Ste. 215<br>Yuba City, CA 95991        |                     |                                 |   |
| Upadhyay, M.D., Ajay                   | 365 Hawthorne Ave.,<br>Ste. 101<br>Oakland, CA 94609        | (510) 465-5523      | Alta Bates Summit               | 350 Hawthorne Ave.<br>Oakland, CA 94609                     |

**Health Net of California, Inc. Bariatric Surgery Performance Centers**
**Southern California**

| <b>Surgeon name and group</b>                   | <b>Physician address</b>   | <b>Telephone number</b> | <b>Center name</b>                      | <b>Center address</b>                                   |
|---|--|-------------------------|---|---|
| Ali, M.D., Mir B.<br>LePort Surgical Associates | 18111 Brookhurst St.,<br>Ste. 5600<br>Fountain Valley, CA<br>92708 | (714) 861-4666          | Fountain Valley Regional Hospital       | 17100 Euclid St.<br>Fountain Valley, CA<br>92708        |
|   |  |                         | Orange Coast Memorial Medical Center    | 9920 Talbert Ave.<br>Fountain Valley, CA<br>92708       |
| Bernstein, M.D, David                           | 401 East Highland Ave., Ste. 351<br>San Bernardino, CA<br>92404    | (909) 475-8611          | St. Bernardine Medical Center           | 2101 North Waterman Ave.<br>San Bernardino, CA<br>92404 |
| Bhojrul, M.D., Sunil                            | 9850 Genesee Ave.,<br>Ste. 570<br>La Jolla, CA 92037               | (858) 457-4917          | Scripps La Jolla                        | 10140 Campus Point Dr.<br>San Diego, CA 92121           |
| Billy, M.D., Helmuth                            | 3200 Telegraph Rd.<br>Ventura, CA 93003                            | (805) 676-9100          | St. John's Regional Hospital            | 1600 N. Rose St.<br>Oxnard, CA 93030                    |
| Braverman, M.D., Justin                         | 12462 Putnam St.,<br>Ste. 500<br>Whittier, CA 90602                | (562) 789-5449          | PIH Whittier                            | 12401 Washington Blvd.<br>Whittier, CA 90602            |
| Chen, M.D., Yijun                               | 200 UCLA Medical Plaza<br>Ste. 214<br>Los Angeles, CA 90095        | (310) 794-7788          | Ronald Regan UCLA Medical Center        | 757 Westwood Plaza<br>Los Angeles, CA<br>90095          |
| Daly, M.D., Shaun                               | 101 The City Drive Bldg., 22C, 3rd Floor<br>Orange, CA 92868       | 1-888-717-4463          | University of California, Irvine        | 333 City Blvd.<br>Orange, CA 92868                      |
| Dobrowolsky, M.D., Adrian                       | 1510 San Pablo St.,<br>HCC I, Ste. 514<br>Los Angeles, CA 90033    | (323) 442-6868          | University of Southern California (USC) | 1500 San Pablo St.<br>Los Angeles, CA<br>90033          |
| Dutson, M.D., Erik                              | 200 UCLA Medical Plaza, Ste. 214<br>Los Angeles, CA 90095          | (310) 794-7788          | Ronald Reagan UCLA Medical Center       | 757 Westwood Plaza<br>Los Angeles, CA<br>90095          |

**Health Net of California, Inc. Bariatric Surgery Performance Centers**
**Southern California, continued**

| <b>Surgeon name and group</b> | <b>Physician address</b>   | <b>Telephone number</b> | <b>Center name</b>  | <b>Center address</b>                                      |
|-------------------------------|--|-------------------------|---|--|
| Ellner, M.D., Julie           | 5555 Reservoir Dr.,<br>Ste. 203<br>San Diego, CA 92120             | (619) 229-3340          | Alvarado<br>Hospital Medical<br>Center                      | 6655 Alvarado Rd.<br>San Diego, CA 92120                   |
| Francis, M.D., Kelly          | 18111 Brookhurst St.,<br>Ste. 6400<br>Fountain Valley, CA<br>92708 | (714) 350-7258          | Fountain Valley<br>Regional<br>Hospital                     | 17100 Euclid St.<br>Fountain Valley, CA<br>92708           |
|                               |  |                         | Orange Coast<br>Memorial<br>Medical Center                  | 9920 Talbert Ave.<br>Fountain Valley, CA<br>92708          |
| Fuller, M.D., William         | 10666 N. Torrey Pines<br>Rd., MS 213<br>La Jolla, CA 92037         | (714) 861-4666          | Scripps Mercy<br>Hospital                                   | 4077 Fifth Ave.,<br>Mer 7<br>San Diego, CA 92103           |
| N/A                           | N/A  | N/A                     | Scripps Green<br>Hospital                                   | 10666 North Torrey<br>Pines Rd.<br>La Jolla, CA 92037      |
| Hanna, M.D., Karen            | 2385 S. Melrose Dr.<br>Vista, CA 92081                             | (760) 300-3647          | Palomar Medical<br>Center (aka<br>Pomerado)                 | 15615 Pomerado Rd.<br>Poway, CA 92064                      |
| Hinojosa, M.D.,<br>Marcelo    | 101 The City Drive<br>Bldg., 22C, 3rd Floor<br>Orange, CA 92868    | 1-888-717-4463          | University of<br>California, Irvine                         | 333 City Blvd.<br>Orange, CA 92868                         |
| Horgan, M.D., Santiago        | 9350 Campus Point<br>Dr., Ste. 2A<br>La Jolla, CA 92037            | (619) 471-0701          | University of<br>California, San<br>Diego Medical<br>Center | 9300 Campus Point<br>Dr.<br>La Jolla, CA 92037             |
| Jacobsen, M.D., Garth         | 4520 Executive Dr.,<br>Ste. 111<br>San Diego, CA 92121             | (858) 657-8860          | University of<br>California, San<br>Diego Medical<br>Center | 9300 Campus Point<br>Dr.<br>La Jolla, CA 92037             |
| Krahn, M.D., Douglas          | 401 East Highland<br>Ave., Ste. 351<br>San Bernardino, CA<br>92404 | (909) 475-8611          | Chapman<br>Medical Center                                   | 2601 E. Chapman<br>Ave.<br>Orange, CA 92869                |
|                               |  |                         | St. Bernardine<br>Medical Center                            | 2101 North<br>Waterman Ave.<br>San Bernardino, CA<br>92404 |



**Health Net of California Bariatric Surgery Performance Centers**
**Southern California, continued**

| <b>Surgeon name and group</b>                               | <b>Physician address</b>                                     | <b>Telephone number</b> | <b>Center name</b>                      | <b>Center address</b>                            |
|---|--|-------------------------|---|--|
| Lamar, M.D., Troy<br>California Bariatric & General Surgery | 51 N. 5th Ave., Ste. 202<br>Arcadia, CA 91006                | (626) 445-0600          | Methodist Hospital                      | 300 West Huntington Dr.<br>Arcadia, CA 91007     |
| Lim, M.D., Lian   | 10666 N. Torrey Pines Rd., MS 213<br>La Jolla, CA 92037      | (858) 554-8984          | Scripps Mercy Hospital                  | 4077 Fifth Ave.,<br>Mer 7<br>San Diego, CA 92103 |
| Mueller, M.D., George                                       | 7910 Frost St., Ste. 250<br>San Diego, CA 92123              | (858) 565-0104          | Sharp Memorial Hospital                 | 7901 Frost St.<br>San Diego, CA 92123            |
| Nguyen, M.D., James   | 1510 San Pablo St., Ste. 6200<br>Los Angeles, CA 90033       | (800) 872-2273          | University of Southern California (USC) | 1500 San Pablo St.<br>Los Angeles, CA 90033      |
| Nguyen, M.D., Ninh  | 101 The City Drive Bldg., 22C, 3rd Floor<br>Orange, CA 92868 | 1-888-717-4463          | University of California, Irvine        | 333 City Blvd.<br>Orange, CA 92868               |
| Oliak, M.D., David  | 255 West Central Ave., Ste. 203<br>Brea, CA 92821            | (714) 582-2530          | Chapman Medical Center                  | 2601 E. Chapman Ave.<br>Orange, CA 92869         |
| Paya, M.D., Mahbod  | 7320 Woodlake Ave., Ste. 170<br>West Hills, CA 91307         | (818) 888-7090          | West Hills Hospital Medical Center      | 7300 Medical Center Dr.<br>West Hills, CA 91307  |
| Powell, M.D., Wes   | 950 S. Arroyo Parkway, 3rd Floor<br>Pasadena, CA 91105       | (626) 449-0694          | Methodist Hospital                      | 300 West Huntington Dr.<br>Arcadia, CA 91007     |
| Quilici, M.D., Philippe                                     | 201 South Buena Vista St., Ste. 425<br>Burbank, CA 91505     | (818) 848-8311          | Providence St. Joseph Medical Center    | 501 S. Buena Vista<br>Burbank, CA 91505          |
| Russo, M.D., Michael  | 18111 Brookhurst St., Ste. 5600<br>Fountain Valley, CA 92708 | (714) 861-4666          | Fountain Valley Regional Hospital       | 17100 Euclid St.<br>Fountain Valley, CA 92708    |
|   |  |                         | Orange Coast Memorial Medical Center    | 9920 Talbert Ave.<br>Fountain Valley, CA 92708   |
| Samakar, M.D., Kamran                                       | 1450 San Pablo St., 6th Floor<br>Los Angeles, CA 90033       | (800) 872-2273          | University of Southern California (USC) | 1500 San Pablo St.<br>Los Angeles, CA 90033      |

**Health Net of California Bariatric Surgery Performance Centers**
**Southern California, continued**

| <b>Surgeon name and group</b> | <b>Physician address</b>  | <b>Telephone number</b> | <b>Center name</b>                          | <b>Center address</b>                                 |
|-------------------------------|---|-------------------------|---|---|
| Smith, M.D., Brian            | 101 The City Drive<br>Bldg., 22C, 3rd Floor<br>Orange, CA 92868 | 1-888-717-4463          | University of<br>California, Irvine         | 333 City Blvd.<br>Orange, CA 92868                    |
| Suh, M.D., David              | 2083 Compton Ave.,<br>Ste. 104<br>Corona, CA 92881              | (951) 256-8191          | Inland Regional<br>Valley Medical<br>Center | 36485 Inland Valley<br>Dr.<br>Wildomar, CA 92595      |
|                               | 25495 Medical Center<br>Dr., Ste. 203<br>Murietta, CA 92562     |                         |   |   |
| Takata, M.D., Mark            | 10666 N. Torrey Pines<br>Rd., MS 213<br>La Jolla, CA 92037      | (714) 861-4666          | Scripps Green<br>Hospital                   | 10666 North Torrey<br>Pines Rd.<br>La Jolla, CA 92037 |
| Thoman, M.D., David           | 520 W. Junipero St.<br>Santa Barbara, CA<br>93105               | (805) 730-1470          | Santa Barbara<br>Cottage Hospital           | 2400 Bath St.<br>Santa Barbara, CA<br>93105           |
| Wittgrove, M.D., Alan         | 12865 Point Del Mar<br>Way, Ste. 130<br>Del Mar, CA 92014       | (858) 350-4700          | Scripps La Jolla                            | 10140 Campus Point<br>Dr.<br>San Diego, CA 92121      |

<sup>1</sup>U.C. Davis Medical Center is limited to performing Roux-en-y gastric bypass and revision gastric bypass surgeries for participating Health Net members not capitated by U.C. Davis Medical Group.

<sup>2</sup>Limited to providing bariatric surgery services to Sutter Health Net members only.



# Care Management Referral Form



DIRECTIONS: Select the member's plan below and email or fax the completed referral.

- **CA Commercial (Ambetter HMO/PPO, Employer Group plans (HMO, PPO, POS)) and Medicare Employer Groups** – Email completed form to Case.Management.Referrals@healthnet.com or fax completed form to **800-745-6955**.
- **CA Medicare** (including Medicare Advantage) for shared risk non-delegated plans. – Email completed form to Medicare\_CM@healthnet.com or fax completed form to **866-290-5957** for physical health care management. Note: For behavioral health care management, refer special needs plan members to MHN via email to mhn.snp@healthnet.com.
- **CA Medi-Cal** – Email completed form to CASHP.ACM.CMA@healthnet.com or fax completed form to **866-581-0540**.

URGENT Request

UC Blue & Gold Plan Member

## Part 1: Referring Source

|                        |               |                |
|------------------------|---------------|----------------|
| First and last name:   |               | Referral date: |
| Office contact person: | Phone number: | Fax number:    |

## Part 2: Member Information

|                             |             |                |
|-----------------------------|-------------|----------------|
| Member first and last name: | Member ID#: | Date of birth: |
| Member address:             | City:       | ZIP Code:      |
| Member phone number:        |             |                |

## Member Diagnosis/Health Condition (check all that apply):

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma<br><input type="checkbox"/> Back pain<br><input type="checkbox"/> Behavioral health<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Autism<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Bursitis/tendonitis<br><input type="checkbox"/> CAD<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Carpal tunnel syndrome<br><input type="checkbox"/> Clinical Trials | <input type="checkbox"/> COPD<br><input type="checkbox"/> Cystic fibrosis<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Frozen shoulder<br><input type="checkbox"/> Golf/tennis elbow<br><input type="checkbox"/> Heart failure<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> High risk pregnancy<br>Estimated date of delivery __/__/__<br><input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypertension<br><input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Migraine/tension headache<br><input type="checkbox"/> Musculoskeletal<br><input type="checkbox"/> Obesity-weight management<br><input type="checkbox"/> Osteoarthritis<br><input type="checkbox"/> Prematurity and/or developmental delay<br><input type="checkbox"/> Rheumatoid arthritis<br><input type="checkbox"/> Sickle cell<br><input type="checkbox"/> Transplant<br><input type="checkbox"/> Traumatic brain injury<br><input type="checkbox"/> Other: _____ |
|---|--|--|

## Please check if any of the following referral reasons apply to the member:

- Concerned about high emergency room utilization or frequent hospitalizations.
- Exhaustion of benefits
- Member needs assistance with behavioral health needs.
- Member needs assistance with medical equipment.
- Member needs assistance with resources for:  housing/shelter,  food,  other (specify) \_\_\_\_\_.
- Member needs education on prescriptions and compliance.
- Member needs education/support with managing his/her chronic condition(s).
- Member needs prenatal care education and support services.
- Member needs transportation to medical appointments.
- Safety concerns.
- Other (specify) \_\_\_\_\_

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Please use this page to provide additional information (as needed).



Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

\_\_\_\_\_  
Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address





## Clinical Policy: Measurement of Serum 1,25-dihydroxyvitamin D

Reference Number: CP.MP.152

Effective Date: 12/17

Last Review Date: 12/17

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Vitamin D is metabolized in the liver to 25-hydroxyvitamin D [25(OH)D], (also known as calcidiol), and then in the kidney to 1,25-dihydroxyvitamin D [1,25(OH)2D], also known as calcitriol. 25(OH)D is the major circulating form of vitamin D while 1,25(OH)2D is the active form of vitamin D. In individuals at risk for vitamin D deficiency, the best method for determining a person's vitamin D status is to measure a 25(OH)D concentration. Measurement of 1,25(OH)2D is not useful for monitoring the vitamin D status, as it does not reflect vitamin D reserves.<sup>1</sup> This policy address when measurement of 1,25(OH)2D is appropriate and medically necessary.

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that measurement of serum 1,25(OH)2D (CPT 82652) is **medically necessary** for monitoring certain conditions, such as acquired and inherited disorders of vitamin D and phosphate metabolism, including any of the following indications:
  - A. Chronic kidney disease;
  - B. Hereditary phosphate-losing disorders;
  - C. Oncogenic osteomalacia;
  - D. Pseudovitamin D-deficiency rickets;
  - E. Vitamin D-resistant rickets;
  - F. Chronic granuloma-forming disorders (e.g., sarcoidosis and some lymphomas).
  
- II. It is the policy of health plans affiliated with Centene Corporation that measurement of serum 1,25(OH)2D for routine screening of average risk, asymptomatic individuals is **not medically necessary**.

### Background

Vitamin D or calciferol, is a fat-soluble vitamin that plays an important role in calcium homeostasis and bone health. Vitamin D comes in two forms, D<sub>2</sub> and D<sub>3</sub>. It is unique among hormones because the major source of vitamin D is exposure to natural sunlight. Very few foods naturally contain, or are fortified with, vitamin D, thus, the major cause of vitamin D deficiency is inadequate exposure to sunlight.

Vitamin D deficiency is defined by the Endocrine Society as a 25(OH)D below 20 ng/ml (50 nmol/liter). Vitamin D deficiency results in abnormalities in calcium, phosphorus, and bone metabolism. It causes a decrease in the efficiency of intestinal calcium and phosphorus absorption of dietary calcium and phosphorus, resulting in an increase in parathyroid hormone (PTH) levels. Secondary hyperparathyroidism maintains serum calcium in the normal range at

**Measurement of Serum 1,25-dihydroxyvitamin D**

the expense of mobilizing calcium from the skeleton and increasing phosphorus wasting in the kidneys.

Screening for Vitamin D deficiency is recommended for individuals at risk, such as those with osteomalacia, osteoporosis, chronic kidney disease, hepatic failure, malabsorption syndromes, hyperparathyroidism, African-American and Hispanic children and adults, pregnant or lactating women, older adults with history of falls or non-traumatic fractures, obese children or adults (BMI greater than 30 kg/m<sup>2</sup>), granuloma-forming disorders, and some lymphomas.<sup>1</sup>

Circulating 25(OH)D is the best indicator to monitor for vitamin D status as it is the main circulating form of vitamin D, and has a half-life of two to three weeks. In contrast, 1,25(OH)<sub>2</sub>D, has a much shorter half-life of about four hours, circulates in much lower concentrations than 25(OH)D, and is susceptible to fluctuations induced by PTH in response to subtle changes in calcium levels. Serum 1,25(OH)<sub>2</sub>D is frequently either normal or even elevated in those with vitamin D deficiency, due to secondary hyperparathyroidism.<sup>1</sup>

*The Endocrine Society*

The Endocrine Society recommends using the serum circulating 25-hydroxyvitamin D [25(OH)D] level, measured by a reliable assay, to evaluate vitamin D status in patients who are at risk for vitamin D deficiency and in whom a prompt response to optimization of vitamin D status could be expected. They note further, 1,25(OH)<sub>2</sub>D measurement does not reflect vitamin D status as levels are tightly regulated by serum levels of PTH, calcium, and phosphate. Serum 1,25(OH)<sub>2</sub>D does not reflect vitamin D reserves, and measurement of 1,25(OH)<sub>2</sub>D is not useful for monitoring the vitamin D status of patients. Serum 1,25(OH)<sub>2</sub>D is frequently either normal or even elevated in those with vitamin D deficiency, due to secondary hyperparathyroidism. Measurement of 1,25(OH)<sub>2</sub>D is useful in acquired and inherited disorders in the metabolism of 25(OH)D and phosphate, including chronic kidney disease, hereditary phosphate-losing disorders, oncogenic osteomalacia, pseudovitamin D-deficiency rickets, vitamin D-resistant rickets, as well as chronic granuloma-forming disorders such as sarcoidosis and some lymphomas.

*United States Preventive Services Task Force (USPSTF)*

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults.

*American Congress of Obstetricians and Gynecologists*

At this time, there is insufficient evidence to support a recommendation for screening all pregnant women for vitamin D deficiency. For pregnant women thought to be at increased risk of vitamin D deficiency, maternal serum 25-hydroxyvitamin D levels can be considered and should be interpreted in the context of the individual clinical circumstance.

**Coding Implications**

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**Measurement of Serum 1,25-dihydroxyvitamin D**

included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| <b>CPT® Codes</b> | <b>Description</b>   |
|-------------------|--|
| 82306             | Vitamin D; 25 hydroxy, includes fraction(s), if performed      |
| 82652             | Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed |

| <b>HCPCS Codes</b> | <b>Description</b> |
|--------------------|--------------------|
| N/A                |                    |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

| <b>ICD-10-CM Code</b> | <b>Description</b>  |
|-----------------------|---|
| A15.0-A15.9           | Respiratory tuberculosis  |
| C81.00-C81.99         | Hodgkin lymphoma  |
| C82.00-C82.99         | Follicular lymphoma   |
| C83.00-C83.99         | Non-follicular lymphoma   |
| C84.00-C84.99         | Mature T/NK-cell lymphomas  |
| C88.0-C88.9           | Malignant immunoproliferative diseases and certain other B-cell lymphomas |
| D86.0-D86.9           | Sarcoidosis   |
| E20.00                | Idiopathic hypoparathyroidism   |
| E20.8                 | Other hypoparathyroidism  |
| E21.0-E21.9           | Hyperparathyroidism and other disorders of parathyroid gland              |
| E55.0                 | Rickets, active   |
| E83.30-E83.39         | Disorder of phosphorus metabolism and phosphatases                        |
| E83.50-E83.59         | Disorders of calcium metabolism   |
| N18.1-N18.9           | Chronic kidney disease (CKD)  |
| N25.0                 | Renal osteodystrophy  |
| P37.0                 | Congenital tuberculosis   |

| <b>Reviews, Revisions, and Approvals</b> | <b>Date</b> | <b>Approval Date</b> |
|--|-------------|----------------------|
| Policy developed                         | 11/17       | 12/17                |

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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

**Measurement of Serum 1,25-dihydroxyvitamin D**

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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## Clinical Policy: Helicobacter Pylori Serology Testing

Reference Number: CP.MP.153

Effective Date: 12/17

Last Review Date: 12/17

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

*Helicobacter pylori* (*H. pylori*) is the most prevalent chronic bacterial infection and is associated with peptic ulcer disease, chronic gastritis, gastric adenocarcinoma, and gastric mucosa associated lymphoid tissue (MALT) lymphoma. Noninvasive tests for the diagnosis of *H. pylori* include urea breath testing (UBT), stool antigen testing, and serology.<sup>1</sup>

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that *H. pylori* serology testing is **not medically necessary** for diagnosing infection or evaluating treatment effectiveness.

### Background

The most common causes of peptic ulcer disease (PUD) are *H. pylori* infection and use of nonsteroidal anti-inflammatory drugs (NSAIDs). *H. pylori* infection causes progressive functional and structural gastroduodenal damage.<sup>4</sup> Accurate diagnosis of *H. pylori* infection is a crucial part in the effective management of many gastroduodenal diseases. Several invasive and non-invasive diagnostic tests are available for the detection of *H. pylori* and each test has its usefulness and limitations in different clinical situations.<sup>8</sup>

Urea breath tests and stool antigen tests are the most widely used non-invasive tests for identifying *H. pylori* infection, as well as most accurate. In addition, they can be used to confirm cure. Serologic tests are a convenient but less accurate alternative and cannot be used to confirm cure.<sup>2</sup> Serology testing is useful in screening and epidemiological studies.<sup>6</sup> For patients without alarm symptoms (e.g., weight loss, progressive dysphagia, recurrent vomiting, evidence of gastrointestinal bleeding, or family history of cancer), noninvasive testing for *H. pylori*, with either carbon-13-labeled urea breath testing or stool antigen testing, is recommended as a first-line strategy.<sup>4</sup>

The urea breath test is the noninvasive test of choice for the diagnosis of *H. pylori*, with high sensitivity (95%) and specificity (95% to 100%) for the detection of active *H. pylori* infections.<sup>4</sup> Urea breath tests require the ingestion of urea labeled with the nonradioactive isotope carbon 13 or carbon 14. Specificity and sensitivity approach 100%. Urea breath testing is an option for test of cure and should be performed four to six weeks after completion of eradication therapy. Proton pump inhibitors (PPIs) must be stopped for at least two weeks before the test, and accuracy is lower in patients who have had distal gastrectomy.<sup>2</sup>

Stool antigen tests using monoclonal antibodies are as accurate as urea breath tests if a validated laboratory-based monoclonal test is used. Like urea breath tests, stool antigen tests detect only

**Helicobacter Pylori Serology Testing**

active infection and can also be used as a test of cure. PPIs should be stopped for two weeks before testing, but stool antigen tests are not as affected by PPI use.<sup>2</sup>

Serologic antibody testing detects immunoglobulin G specific to *H. pylori* in serum and cannot distinguish between an active infection and a past infection.<sup>2</sup> Most common serologic tests are based on an enzyme-linked immunosorbent assay (ELISA) technology. As with any test, prevalence of the *H. pylori* infection and the pretest probability influence the positive or negative predictive values. Overall, where the prevalence of *H. pylori* infection and the pretest probability are low, the negative predictive value of a serologic test is high whereas false positives are more frequent, with the opposite in high prevalence/high pretest probability cases (i.e., the positive predictive value is high but there is increased prevalence of false negative results).<sup>4</sup> Antibody testing cannot be used as a test of cure.

*American Society for Clinical Pathology*

Serologic evaluation of patients to determine the presence/absence of *H. pylori* infection is no longer considered clinically useful. Alternative noninvasive testing methods (e.g., the urea breath test and stool antigen test) exist for detecting the presence of the bacteria and have demonstrated higher clinical utility, sensitivity, and specificity.

*The American Gastroenterological Association (AGA)*

The AGA no longer recommends serology-based testing for diagnosing infection or evaluating treatment effectiveness as it is unable to distinguish between active infection and previous exposure to *H. pylori*, does not confirm eradication and has a poor positive predictive value when compared to active infection tests such as the urea breath test or stool antigen test.<sup>7</sup>

*The American College of Gastroenterology*

All patients with active PUD, a past history of PUD (unless previous cure of *H. pylori* infection has been documented), low-grade gastric MALT lymphoma, or a history of endoscopic resection of early gastric cancer should be tested for *H. pylori* infection. In patients with uninvestigated dyspepsia who are under the age of 60 years and without alarm features, non-endoscopic testing for *H. pylori* infection is a consideration. Other indications to test patients for *H. pylori* infection may include, patients taking long-term low-dose aspirin, patients initiating chronic treatment with an NSAID, patients with unexplained iron deficiency anemia despite an appropriate evaluation and adults with idiopathic thrombocytopenic purpura. Any individual who tests positive should be offered eradication therapy.<sup>3</sup> Patients with a history of PUD who have previously been treated for *H. pylori* infection should undergo eradication testing with a urea breath test or fecal antigen test.<sup>3</sup>

**Coding Implications**

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**Helicobacter Pylori Serology Testing**

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| <b>CPT® Codes</b> | <b>Description</b>            |
|-------------------|-------------------------------|
| 86677             | Antibody; Helicobacter pylori |

| <b>HCPCS Codes</b> | <b>Description</b> |
|--------------------|--------------------|
| N/A                |                    |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

| <b>ICD-10-CM Code</b> | <b>Description</b> |
|-----------------------|--------------------|
| N/A                   |                    |

| <b>Reviews, Revisions, and Approvals</b> | <b>Date</b> | <b>Approval Date</b> |
|--|-------------|----------------------|
| Policy developed                         | 12/17       | 12/17                |

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**Helicobacter Pylori Serology Testing**

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### Helicobacter Pylori Serology Testing

Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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# Clinical Policy: Thyroid Hormones and Insulin Testing in Pediatrics

Reference Number: CP.MP.154

Effective Date: 12/17

Last Review Date: 12/17

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

Numerous essential metabolic functions are mitigated by hormones produced by, and affecting the thyroid, *e.g.*, thyroid stimulating hormone [TSH] and thyroxine [T4], as well as by insulin. This policy discusses the medical necessity requirements for the testing of these hormones.

## Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that thyroid hormone testing in healthy, including obese but otherwise healthy, children (age  $\geq 1$  and  $\leq 18$ ) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.
- II. It is the policy of health plans affiliated with Centene Corporation that insulin testing in healthy, including obese but otherwise healthy, children (age  $\geq 1$  and  $\leq 18$ ) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.

## Background

The thyroid is an endocrine gland that regulates numerous metabolic processes through hormone secretion. Thyroid homeostasis is controlled through a complex feedback loop through the hypothalamus-pituitary-thyroid axis. Thyroxine (otherwise known as T4 due to the presence of four iodine molecules) is the major secretory hormone of the thyroid, and is converted into triiodothyronine (T3). Secretion of thyroxine by the thyroid is regulated by the concentration of thyroid stimulating hormone (TSH). TSH is generated by the pituitary gland and secreted in the bloodstream to generate a feedback loop with T4. Loss of the regulatory feedback cycle of the thyroid hormones could lead to hyperthyroidism and primary or secondary hypothyroidism.

Assessment of thyroid function can be achieved through the quantification of thyroid hormone levels. However, the appropriate clinical utilization of these tests has been a subject of concern in the recent literature.<sup>1,2</sup> For example in pediatrics, TSH and total T4 can be elevated in children who are overweight or obese, but it is not clear if this is a result or cause of obesity.<sup>3,4,5</sup> Therefore general screening may not provide actionable clinical information.<sup>3-7</sup>

The Endocrine Society Clinical Practice Guideline on pediatric obesity recommends against routine laboratory evaluations for endocrine etiologies of pediatric obesity unless the patient's stature and/or height velocity are attenuated (assessed in relationship to genetic/familial potential and pubertal stage). They also recommend against measuring insulin concentrations when evaluating children or adolescents for obesity. They note that although obesity is associated with insulin resistance/hyperinsulinemia, attempts to diagnose insulin resistance by measuring plasma insulin concentration or any other surrogate in the clinical setting has no merit because it has no diagnostic value. Fasting insulin concentrations show considerable overlap between insulin-

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resistant and insulin-sensitive youths. Therefore, there is no well-defined cut point differentiating normal from abnormal and no universally accepted, clinically useful, numeric expression that defines insulin resistance, unlike for glucose or lipids. Moreover, measuring insulin is hampered by the lack of standardized insulin assays, and poor reproducibility of even the same assay. Further limitations include race/ethnicity-related differences in insulin concentrations due to differences in the metabolic clearance rate of insulin and the cross reactivity between insulin and proinsulin. In youths with Type 2 diabetes mellitus, despite severe deficiency in insulin secretion, fasting insulin concentrations are higher than in youths without diabetes. Importantly, fasting insulin concentrations are similar in youths who are obese with normal glucose tolerance vs impaired glucose tolerance, allowing for the possible danger of missing a diagnosis of impaired glucose tolerance if one uses fasting insulin concentrations as a screening tool. Because of these limitations, measuring plasma insulin concentrations remains a research tool with no clinical value for evaluation of obesity.<sup>7</sup>

**Coding Implications**

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**Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2**

| CPT® Codes | Description   |
|------------|---|
| 83525      | Insulin; total  |
| 83527      | Insulin; free   |
| 84436      | Thyroxine; total  |
| 84439      | Thyroxine; free   |
| 84443      | Thyroid stimulating hormone (TSH)   |
| 84479      | Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR) |
| 84480      | Triiodothyronine T3; total (TT-3)   |
| 84481      | Triiodothyronine T3; free   |
| 84482      | Triiodothyronine T3; reverse  |

**Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.**

| ICD-10-CM Code | Description                                    |
|----------------|--|
| E66.01         | Morbid (severe) obesity due to excess calories |
| E66.09         | Other obesity due to excess calories           |
| E66.1          | Drug-induced obesity                           |
| E66.3          | Overweight                                     |

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| ICD-10-CM Code | Description  |
|----------------|--|
| E66.8          | Other obesity  |
| E66.9          | Obesity, unspecified   |
| Z00.00         | Encounter for general adult medical examination without abnormal findings                                    |
| Z00.129        | Encounter for routine child health examination without abnormal findings                                     |
| Z00.8          | Encounter for other general examination  |
| Z68.52         | Body mass index (BMI) pediatric, 5 <sup>th</sup> percentile to less than 85 <sup>th</sup> percentile for age |
| Z68.53         | BMI pediatric, 85 <sup>th</sup> percentile to less than 95 <sup>th</sup> percentile for age                  |
| Z68.54         | BMI pediatric, greater than or equal to 95 <sup>th</sup> percentile for age                                  |

| Reviews, Revisions, and Approvals | Date  | Approval Date |
|-----------------------------------|-------|---------------|
| Policy developed                  | 12/17 | 12/17         |

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**Important Reminder**

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### Thyroid Hormone and Insulin Testing

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.



## CLINICAL POLICY

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**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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## Clinical Policy: EEG in the Evaluation of Headache

Reference Number: CP.MP.155

Effective Date: 12/17

Last Review Date: 12/17

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

An electroencephalogram (EEG) is a non-invasive method for assessing neurophysiological function. EEG measures the electrical activity that is recorded from many different standard sites on the scalp according to the international (10 to 20) electrode placement system. It is a useful diagnostic test in evaluating epilepsy. This policy addresses the use of EEG in the diagnostic evaluation of headache.

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that an EEG in the routine evaluation of headache is **not medically necessary**. EEG has not been convincingly shown to identify headache subtypes, nor has it been shown to be an effective screening tool for structural causes of headache.

### Background

An EEG is an important diagnostic test in the evaluation of a patient with possible epilepsy, providing evidence that helps confirm or refute the diagnosis, as well as guide management. An EEG may also be performed for other indications, including but not limited to, states of altered consciousness, cerebral infections, and various other encephalopathies.

Headache is a common disorder with many potential causes. The primary headaches, which include migraine, tension-type headache and cluster headache, are benign and account for the majority of headaches. They are usually recurrent and have no organic disease as their cause. Secondary headaches, are less common and caused by underlying organic diseases ranging from sinusitis to subarachnoid hemorrhage.<sup>3</sup> In most instances, the physician can accurately diagnose a patient's headache and determine whether additional laboratory testing or neuroimaging is indicated by considering the various headache types in each category (primary or secondary), obtaining a thorough headache history and performing a focused clinical examination.<sup>4</sup>

The presence of warning signs of a possible disorder, other than primary headache, that should prompt further investigation (e.g. limited laboratory testing, neuroimaging, lumbar puncture) include:

- Subacute and/or progressive headaches that worsen over time (months)
- A new or different headache
- Any headache of maximum severity at onset
- Headache of new onset after age 50
- Persistent headache precipitated by a Valsalva maneuver
- Evidence such as fever, hypertension, myalgias, weight loss or scalp tenderness suggesting a systemic disorder
- Presence of neurological signs that may suggest a secondary cause

**Electroencephalogram in the Evaluation of Headache**

- Seizures

Studies designed to determine whether headache patients have an increased prevalence of EEG abnormalities report conflicting results. The American Academy of Neurology reports that EEG has no advantage over clinical evaluation in diagnosing headache, does not improve outcomes, and increases costs. A literature review of 40 articles describing EEG findings in headache patients reported that studies did not show that the EEG is an effective screen for structural causes of headache, nor does the EEG effectively identify headache subgroups with different prognoses.<sup>5</sup>

*American Academy of Neurology (AAN)*

AAN reports that no study has consistently demonstrated that the EEG improves diagnostic accuracy for the headache sufferer. The AAN makes the following recommendations:

- The EEG is not useful in the routine evaluation of patients with headache (guideline). This does not exclude the use of EEG to evaluate headache patients with associated symptoms suggesting a seizure disorder, such as atypical migrainous aura or episodic loss of consciousness. Assuming head imaging capabilities are readily available, EEG is not recommended to exclude a structural cause for headache (option).<sup>1</sup>
- EEG is not recommended in the routine evaluation of a child with recurrent headaches, as it is unlikely to provide an etiology, improve diagnostic yield, or distinguish migraine from other types of headaches (Level C; class II and class III evidence).<sup>2</sup>
- Although the risk for future seizures is negligible in children with recurrent headache and paroxysmal EEG, future investigations for epilepsy should be determined by clinical follow up (Level C; class II and class III evidence).<sup>2</sup>

*International Headache Society*

The EEG is not included in the diagnostic criteria of the International Headache Society for migraine or any other major headache categories.

**Coding Implications**

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**Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10-CM in Table 2**

| CPT® Codes | Description   |
|------------|---|
| 95812      | Electroencephalogram (EEG) extended monitoring; 41-60 minutes       |
| 95813      | Electroencephalogram (EEG) extended monitoring; greater than 1 hour |

**Electroencephalogram in the Evaluation of Headache**

| CPT® Codes | Description  |
|------------|--|
| 95816      | Electroencephalogram (EEG); including recording awake and drowsy |
| 95819      | Electroencephalogram (EEG); including recording awake and asleep |

| HCPCS Codes | Description |
|-------------|-------------|
| N/A         |             |

**Table 2: ICD-10-CM codes not medically necessary when billed with a corresponding CPT code in Table 1.**

| ICD-10-CM Code     | Description              |
|--------------------|--------------------------|
| G43.00-<br>G43.919 | Migraine                 |
| G44.001-<br>G44.89 | Other headache syndromes |
| R51                | Headache                 |

| Reviews, Revisions, and Approvals | Date  | Approval Date |
|-----------------------------------|-------|---------------|
| Policy developed                  | 12/17 | 12/17         |

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**Electroencephalogram in the Evaluation of Headache**

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## Clinical Policy: Cardiac Biomarker Testing for Acute Myocardial Infarction

Reference Number: CP.MP.156

Effective Date: 12/17

Last Review Date: 12/17

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

The release of cardiac biomarkers is among the cascade of events that occur during acute coronary syndromes and cardiac ischemia. This policy discusses the medical necessity requirements for testing of these cardiac biomarkers.

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that troponin I or T testing is **medically necessary** for suspected acute myocardial infarctions (AMI).
- II. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that creatine kinase myocardial isoenzyme (CK-MB) and myoglobin testing are **not medically necessary** for suspected AMI because these tests have not been demonstrated to have a clear clinical benefit.

### Background

Detection of specific cardiac biomarkers in blood serum is a useful clinical indication of AMI, myocarditis, or heart failure. According to the 2014 clinical practice guideline of the American College of Cardiologists / American Heart Association, (ACC/AHA) cardiac troponins have become the main biomarkers used for the diagnoses of acute coronary syndromes, specifically troponins I and T because these subunits are expressed in the myocardium.<sup>1,2</sup> Furthermore, troponin levels are also elevated for acute and chronic decompensated heart failure in instances of myocyte injury and/or necrosis.<sup>3</sup>

Other cardiac peptides that were previously assessed for AMI include CK-MB and myoglobin. However, recent evidence suggests that the sensitivity and specificity of these biomarkers are inferior compared to the troponins, suggesting that troponins are a more accurate biomarker of myocardial injury.<sup>1</sup> According to the 2014 ACC/AHA clinical practice guideline, CK-MB and myoglobin are no longer necessary for acute coronary syndrome diagnosis as a result of the advent of troponin assays.<sup>1</sup> CK-MB detection is comparatively less sensitive and less specific. Voltz et al. performed a retrospective cohort study across 55,000 emergency department visits for AMI and examined their CK-MB and troponin levels with screenings; the authors concluded that CK-MB can be omitted during the initial screening of AMIs.<sup>6</sup> Eggers et al, evaluated the role of myoglobin with troponin I to detect AMI in a sample of 197 patients and determined that neither myoglobin nor CK-MB added clinical diagnostic value.<sup>4</sup> Aviles et al analyzed AMI amongst patients with elevated cardiac troponins in a prospective cohort and noted that at least 20% of patients had normal CK-MB levels, thereby further questioning the validity of CK-MB as a valuable cardiac biomarker.<sup>7</sup> Of note, Singh *et al.* measured CK-MB testing from 2007 to 2013 and found a dramatic decrease from 12,057 tests in 2007 to 36 tests in 2013.<sup>5</sup>

**Cardiac Biomarker Testing for Acute Myocardial Infarction**

**Coding Implications**

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**Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2**

| CPT® Codes | Description                                   |
|------------|---|
| 82553      | Creatine kinase (CK), (CPK); MB fraction only |
| 83874      | Myoglobin                                     |

**Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.**

| ICD-10-CM Code | Description  |
|----------------|--|
| I20.0          | Unstable angina  |
| I20.1          | Angina pectoris with documented spasm  |
| I20.8          | Other forms of angina pectoris   |
| I20.9          | Angina pectoris, unspecified   |
| I21.01         | ST elevation (STEMI) myocardial infarction involving left main coronary artery |
| I21.02         | STEMI myocardial infarction involving left anterior descending coronary artery |
| I21.09         | STEMI myocardial infarction involving other coronary artery of anterior wall   |
| I21.11         | STEMI myocardial infarction involving right coronary artery                    |
| I21.19         | STEMI myocardial infarction involving other coronary artery of inferior wall   |
| I21.21         | STEMI myocardial infarction involving left circumflex coronary artery          |
| I21.29         | STEMI myocardial infarction involving other sites                              |
| I21.3          | STEMI myocardial infarction of unspecified site                                |
| I21.4          | Non-ST elevation (NSTEMI) myocardial infarction                                |
| I21.9          | Acute myocardial infarction, unspecified                                       |
| I21.A1         | Myocardial infarction type 2   |
| I21.A9         | Other myocardial infarction type   |
| I22.0          | Subsequent STEMI myocardial infarction of anterior wall                        |
| I22.1          | Subsequent STEMI myocardial infarction of inferior wall                        |
| I22.2          | Subsequent NSTEMI myocardial infarction  |
| I22.8          | Subsequent STEMI myocardial infarction of other sites                          |
| I22.9          | Subsequent STEMI myocardial infarction of unspecified site                     |

**Cardiac Biomarker Testing for Acute Myocardial Infarction**

| <b>ICD-10-CM Code</b> | <b>Description</b>  |
|-----------------------|---|
| I23.7                 | Postinfarction angina   |
| I24.0                 | Acute coronary thrombosis not resulting in myocardial infarction  |
| I24.8                 | Other forms of acute ischemic heart disease   |
| I24.9                 | Acute ischemic heart disease, unspecified   |
| I25.10                | Atherosclerotic heart disease of native coronary artery without angina pectoris                                 |
| I25.110               | Atherosclerotic heart disease of native coronary artery with unstable angina pectoris                           |
| I25.111               | Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm              |
| I25.118               | Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris                     |
| I25.119               | Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris                        |
| I25.2                 | Old myocardial infarction   |
| I25.41                | Coronary artery aneurysm  |
| I25.42                | Coronary artery dissection  |
| I25.5                 | Ischemic cardiomyopathy   |
| I25.6                 | Silent myocardial ischemia  |
| I25.700               | Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris                  |
| I25.701               | Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm     |
| I25.708               | Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris            |
| I25.709               | Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris               |
| I25.710               | Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris                |
| I25.711               | Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm   |
| I25.718               | Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris          |
| I25.719               | Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris             |
| I25.720               | Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris              |
| I25.721               | Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm |
| I25.728               | Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris        |
| I25.729               | Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris           |

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| <b>ICD-10-<br/>CM Code</b> | <b>Description</b>   |
|----------------------------|--|
| I25.730                    | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris              |
| I25.731                    | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm |
| I25.738                    | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris        |
| I25.739                    | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris           |
| I25.750                    | Atherosclerosis of native coronary artery of transplanted heart with unstable angina                                   |
| I25.751                    | Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm             |
| I25.758                    | Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris                    |
| I25.759                    | Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris                       |
| I25.760                    | Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina                          |
| I25.761                    | Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm    |
| I25.768                    | Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris           |
| I25.769                    | Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris              |
| I25.790                    | Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris                                 |
| I25.791                    | Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm                    |
| I25.798                    | Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris                           |
| I25.799                    | Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris                              |
| I25.810                    | Atherosclerosis of coronary artery bypass graft(s) without angina pectoris   |
| I25.811                    | Atherosclerosis of native coronary artery of transplanted heart without angina pectoris                                |
| I25.812                    | Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris                       |
| I25.82                     | Chronic total occlusion of coronary artery   |
| I25.83                     | Coronary atherosclerosis due to lipid rich plaque  |
| I25.84                     | Coronary atherosclerosis due to calcified coronary lesion  |
| I25.89                     | Other forms of chronic ischemic heart disease  |
| I25.9                      | Chronic ischemic heart disease, unspecified  |
| R07.0                      | Pain in throat   |

**Cardiac Biomarker Testing for Acute Myocardial Infarction**

| ICD-10-CM Code | Description             |
|----------------|-------------------------|
| R07.1          | Chest pain on breathing |
| R07.2          | Precordial pain         |
| R07.81         | Pleurodynia             |
| R07.82         | Intercostal pain        |
| R07.89         | Other chest pain        |
| R07.9          | Chest pain, unspecified |

| Reviews, Revisions, and Approvals | Date  | Approval Date |
|-----------------------------------|-------|---------------|
| Policy developed                  | 12/17 | 12/17         |

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**Cardiac Biomarker Testing for Acute Myocardial Infarction**

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**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

**CLINICAL POLICY****Cardiac Biomarker Testing for Acute Myocardial Infarction**

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## Clinical Policy: 25-hydroxyvitamin D Testing in Children and Adolescents

Reference Number: CP.MP.157

Effective Date: 12/17

Last Review Date: 12/17

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

A global consensus statement recommends against universal screening for vitamin D deficiency in healthy children as there is insufficient evidence that the potential benefits of testing outweigh the potential harms.<sup>2</sup>

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that 25-hydroxyvitamin D testing in healthy, including obese but otherwise healthy, children (age  $\geq 1$  and  $\leq 18$ ) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.

### Background

Measurement of 25-OH-D (25-hydroxyvitamin D) concentration is the appropriate screening test for vitamin D deficiency, as opposed to 1,25-OH<sub>2</sub>-D, which has little to no predictive value related to bone health.<sup>6</sup> However, there is lack of agreement concerning the best type of assay to conduct when measuring 25-hydroxyvitamin D.<sup>4</sup> Furthermore, there is substantial controversy concerning cutoff levels to define vitamin D deficiency, as the evidence is inconsistent regarding optimal levels of vitamin D.<sup>1</sup>

Prevalence of vitamin D deficiency in children (defined in the study as levels  $< 20$  ng/mL) is estimated to be about 14%, although estimates range from 14% to 37%.<sup>3,6</sup> Rates of deficiency vary among certain populations, with increased risk among black and Hispanic teenagers, as well as overweight and obese children and adolescents.<sup>6</sup> Reduced serum vitamin D in overweight and obese children and adolescents reflects sequestration in adipose tissue, but little is known about the significance of low serum vitamin D in this population.<sup>4</sup>

A global consensus of 33 experts, convened at the request of the European Society for Pediatric Endocrinology, reviewed the available literature on prevention and management of nutritional rickets, and determined that routine vitamin D screening is not recommended for healthy children.<sup>2</sup> They note the frequent coexistence of dietary calcium and vitamin D deficiency, which alters the threshold for development of rickets, and makes a single screening value impractical.<sup>2</sup> The global consensus panel advocates for identification and screening of groups at high risk for vitamin D deficiency based on clinical factors, as opposed to universal screening as public health policy.

The American Academy of Pediatrics (AAP) – Section on Endocrinology advises against ordering vitamin D concentrations routinely in otherwise healthy children, including children who are overweight or obese.<sup>5</sup> The AAP's report on optimizing bone health recommends

screening for vitamin D deficiency only in children and adolescents with conditions associated with reduced bone mass and/or recurrent low-impact fractures.<sup>6</sup>

For healthy children and adolescents who are not ingesting enough foods with vitamin D, the AAP recommends supplementation with vitamin D, as does the global consensus panel convened by the European Society for Pediatric Endocrinology.

**Coding Implications**

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**Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2**

| CPT® Codes | Description   |
|------------|---|
| 82306      | Vitamin D; 25 hydroxy, includes fraction(s), if performed |

**Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.**

| ICD-10-CM Code | Description  |
|----------------|--|
| E66.01         | Morbid (severe) obesity due to excess calories   |
| E66.09         | Other obesity due to excess calories   |
| E66.1          | Drug-induced obesity   |
| E66.3          | Overweight   |
| E66.8          | Other obesity  |
| E66.9          | Obesity, unspecified   |
| Z00.00         | Encounter for general adult medical examination without abnormal findings                                    |
| Z00.129        | Encounter for routine child health examination without abnormal findings                                     |
| Z00.8          | Encounter for other general examination  |
| Z68.52         | Body mass index (BMI) pediatric, 5 <sup>th</sup> percentile to less than 85 <sup>th</sup> percentile for age |
| Z68.53         | BMI pediatric, 85 <sup>th</sup> percentile to less than 95 <sup>th</sup> percentile for age                  |
| Z68.54         | BMI pediatric, greater than or equal to 95 <sup>th</sup> percentile for age                                  |

| Reviews, Revisions, and Approvals | Date  | Approval Date |
|-----------------------------------|-------|---------------|
| Policy created                    | 12/17 | 12/17         |

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### Hydroxyvitamin D Testing in Children

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## Clinical Policy: Ultrasound in Pregnancy

Reference Number: CP.MP.38

Last Review Date: 06/18

[Revision Log](#)  
[Coding Implications](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

This policy outlines the medical necessity criteria for ultrasound use in pregnancy. Ultrasound is the most common fetal imaging tool used today. Ultrasound is accurate at determining gestational age, fetal number, viability, and placental location; and is necessary for many diagnostic purposes in obstetrics. The determination of the time and type of ultrasound should allow for a specific clinical question(s) to be answered. Ultrasound exams should be conducted only when indicated and must be appropriately documented.

### Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that the following ultrasounds during pregnancy are considered **medically necessary** when the following conditions are met:

- I. [Standard first trimester ultrasound](#) (76801)
- II. [Standard second or third trimester ultrasound](#) (76805)
- III. [Detailed anatomic ultrasound](#) (76811)
- IV. [Transvaginal ultrasound](#) (76817)
- V. [Not medically necessary conditions](#)

- I. One standard *first trimester ultrasound* (76801) is allowed per pregnancy.

Subsequent standard first trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

- II. One standard *second or third trimester ultrasound* (76805) is allowed per pregnancy.

Subsequent standard second or third trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

- III. One *detailed anatomic ultrasound* (76811) is allowed per pregnancy when performed to evaluate for suspected anomaly based on history, laboratory abnormalities, or clinical evaluation; or when there are suspicious results from a limited or standard ultrasound. Further indications include the possibility of fetal growth restriction and multifetal gestation. This ultrasound must be billed with an appropriate high risk diagnosis code from Table 4 below.

A second detailed anatomic ultrasound is considered **medically necessary** if a new maternal fetal medicine specialist group is taking over care, a second opinion is required, or the patient

has been transferred to a tertiary care center in anticipation of delivery of an anomalous fetus requiring specialized neonatal care.

Further anatomic ultrasounds are considered **not medically necessary** as there is inadequate evidence of the clinical utility of multiple detailed fetal anatomic examinations.

**IV. Transvaginal ultrasounds (TVU)** are considered **medically necessary** when conducted in the first trimester for the same indications as a standard first trimester ultrasound, and later in pregnancy to assess cervical length, location of the placenta in women with placenta previa, or after an inconclusive transabdominal ultrasound. Cervical length screening is conducted for women with a history of preterm labor or to monitor a shortened cervix based on Table 1 below. Up to 12 transvaginal ultrasounds are allowed per pregnancy.

**Table 1: Berghella approach to TVU measurement of cervical length for screening singleton gestations**

| Past pregnancy history             | TVU cervical length screening         | Frequency  | Maximum # of TVU |
|------------------------------------|---------------------------------------|--|------------------|
| Prior preterm birth 14 to 27 weeks | Start at 14 weeks and end at 24 weeks | Every 2 weeks as long as cervix is at least 30 mm* | 6                |
| Prior preterm birth 28 to 36 weeks | Start at 16 weeks and end at 24 weeks | Every 2 weeks as long as cervix is at least 30 mm* | 5                |
| No prior preterm birth             | One exam between 18 and 24 weeks      | Once   | 1                |

\* Increase frequency to weekly in women with TVU cervical length of 25 to 29 mm. If <25 mm before 24 weeks, consider cerclage.

**V. 3D and 4D ultrasounds** are considered investigational and are therefore **not medically necessary**. Studies lack sufficient evidence that they alter management over two-dimensional ultrasound in a fashion that improves outcomes.

The following additional procedures are considered **not medically necessary**:

- Ultrasounds performed solely to determine the sex of the fetus or to provide parents with photographs of the fetus;
- Scans for growth evaluation performed less than 2 weeks apart;
- Ultrasound to confirm pregnancy in the absence of other indications;
- A follow-up ultrasound in the first trimester in the absence of pain or bleeding.

**Classifications of fetal ultrasounds include:**

**I. Standard First Trimester Ultrasound - 76801**

A standard first trimester ultrasound is performed before 14 weeks and 0 days of gestation. It can be performed transabdominally, transvaginally, or transperineally. When performed transvaginally, CPT 76817 should be used. It includes an evaluation of the presence, size, location, and number of gestational sac(s); and an evaluation of the gestational sac(s).

Indications for a first trimester ultrasound include the following:

- To confirm an intrauterine pregnancy

- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose and evaluate multiple gestations
- To confirm cardiac activity
- As adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in high risk patients
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy (nuchal translucency) when a part of aneuploidy screening
- To evaluate suspected hydatidiform mole

## **II. Standard Second or Third Trimester Ultrasound - 76805**

A standard ultrasound in the second or third trimester involves an evaluation of fetal presentation and number, amniotic fluid volume, cardiac activity, placental position, fetal biometry, and an anatomic survey.

Indications for a standard second or third trimester ultrasound include the following:

- Screening for fetal anomalies
- Evaluation of fetal anatomy
- Estimation of gestational age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Evaluation of suspected multiple gestation
- Adjunct to amniocentesis or other procedure
- Evaluation of discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Examination of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of suspected ectopic pregnancy
- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation of fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation of prelabor rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa



- Evaluation with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment for findings that may increase the risk of aneuploidy

### **III. Detailed Anatomic Ultrasound - 76811**

A detailed anatomic ultrasound is performed when there is an increased risk of an anomaly based on the history, laboratory abnormalities, or the results of the limited or standard ultrasound.

### **IV. Other Ultrasounds – 76817**

A transvaginal ultrasound of a pregnant uterus can be performed in the first trimester of pregnancy and later in a pregnancy to evaluate cervical length and the position of the placenta relative to the internal cervical os. When this exam is done in the first trimester, the same indications for a standard first trimester ultrasound, 76801, apply.

### **Background**

The Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS) trial showed that routine U/S screening of a low risk population did not lead to improved perinatal outcomes. This was a practice based, multi-center randomized trial. There were no significant differences in birth weight or preterm delivery rates.

Ultrasound is used most often in pregnancy for the estimation of gestational age. It has been shown that the use of multiple biometric parameters can allow for accuracy to within 3-4 days in a mid-trimester study (14-22 weeks). Accurate dating of a pregnancy is crucial as many important decisions might be made based on this date—whether or not to resuscitate an infant delivered prematurely, when to give antenatal steroids, when to electively deliver a term infant, and when to induce for post-dates.

Pregnancy dating with a first trimester or mid-trimester ultrasound will reduce the number of misdated pregnancies and subsequent unnecessary inductions for post-dates pregnancies. Third trimester ultrasounds for pregnancy dating are much less dependable.

Ultrasound is a helpful tool for the evaluation of fetal growth in at-risk pregnancies and the diagnosis of a small-for-gestational age baby (SGA). Those SGA babies with actual chronic hypoxemia and/or malnutrition can be termed growth restricted (FGR) if it is suspected that their growth has been less than optimal.

ACOG does not yet recommend the use of three- or four-dimensional ultrasound as a replacement for any necessary two-dimensional study. ACOG states “the technical advantages of three-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by two-dimensional ultrasonography. Despite these technical advantages, proof of a clinical advantage of three-dimensional ultrasonography in prenatal diagnosis in general still is lacking.”

The Society of Maternal Fetal Medicine specifically addresses what is often considered a level II screening U/S or routine U/S, stating:

“CPT 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it is intended for a known or suspected fetal anatomic or genetic abnormality (i.e., previous anomalous fetus, abnormal scan this pregnancy, etc.). Thus, the performance of CPT 76811 is expected to be rare outside of referral practices with special expertise in the identification of, and counseling about, fetal anomalies.

It is felt by all organizations involved in the codes development and description that only one medically indicated CPT 76811 per pregnancy, per practice is appropriate. Once this detailed fetal anatomical exam (76811) is done, a second one should not be performed unless there are extenuating circumstances with a new diagnosis. It is appropriate to use CPT 76811 when a patient is seen by another maternal-fetal medicine specialist practice, for example, for a second opinion on a fetal anomaly, or if the patient is referred to a tertiary center in anticipation of delivering an anomalous fetus at a hospital with specialized neonatal capabilities.

Follow-up ultrasound for CPT 76811 should be CPT 76816 when doing a focused assessment of fetal size by measuring the BPD [biparietal diameter], abdominal circumference, femur length, or other appropriate measurements, OR a detailed re-examination of a specific organ or system known or suspected to be abnormal. CPT 76805 would be used for a fetal maternal evaluation of the number of fetuses, amniotic/chorionic sacs, survey of intracranial, spinal, and abdominal anatomy, evaluation of a 4-chamber heart view, assessment of the umbilical cord insertion site, assessment of amniotic fluid volume, and evaluation of maternal adnexa when visible when appropriate.”

**Coding Implications**

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**Table 2: CPT® Codes Covered When Supported by Appropriate Diagnosis**

| <b>CPT Codes</b> | <b>Description</b>  |
|------------------|---|
| <b>76801</b>     | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 day), transabdominal approach; single or first gestation       |
| <b>76805</b>     | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥14 weeks 0 day), transabdominal approach; single or first gestation |
| <b>76811</b>     | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal                                     |

| CPT Codes    | Description   |
|--------------|---|
|              | approach; single or first gestation   |
| <b>76817</b> | Ultrasound, pregnant uterus, real time with image documentation, transvaginal |

**Table 3: CPT Codes considered Not Medically Necessary:**

| CPT Codes    | Description   |
|--------------|---|
| <b>76376</b> | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation |
| <b>76377</b> | requiring image post-processing on an independent workstation   |

**Table 4: ICD-10 Diagnosis Codes that Support Medical Necessity for First Detailed Fetal Ultrasound**

| ICD-10-CM Code  | Description   |
|---|---|
| B06.00 – B06.9  | Rubella [German measles]  |
| B50.0 – B54   | Malaria   |
| B97.6   | Parvovirus as the cause of diseases classified elsewhere                                  |
| E66.01  | Morbid (severe) obesity due to excess calories [severe obesity with a BMI of 35 or >]     |
| O09.511 – O09.519   | Supervision of elderly primigravida   |
| O09.521 – O09.529   | Supervision of elderly multigravida   |
| O09.811 – O09.819   | Supervision of pregnancy resulting from assisted reproductive technology                  |
| O24.011 – O24.019,<br>O24.111 – O24.119,<br>O24.311 – O24.319,<br>O24.811 – O24.819,<br>O24.911 – O24.919 | Diabetes mellitus in pregnancy  |
| O30.001 – O30.099   | Twin pregnancy  |
| O30.101 – O30.199   | Triplet pregnancy   |
| O30.201 – O30.299   | Quadruplet pregnancy  |
| O30.801 – O30.899   | Other specified multiple gestation  |
| O31.10x+ - O31.23x+   | Continuing pregnancy after spontaneous abortion / intrauterine death of one fetus or more |
| O33.6xx+  | Maternal care for disproportion due to hydrocephalic fetus                                |
| O33.7xx+  | Maternal care for disproportion due to other fetal deformities                            |
| O35.0xx+  | Maternal care for (suspected) central nervous system malformation in fetus                |
| O35.1xx+  | Maternal care for (suspected) chromosomal abnormality in fetus                            |
| O35.2xx+  | Maternal care for (suspected) hereditary disease in fetus                                 |

**CLINICAL POLICY**  
**Ultrasound in Pregnancy**

| <b>ICD-10-CM Code</b>   | <b>Description</b>   |
|---|--|
| O35.3xx+  | Maternal care for (suspected) damage to fetus from viral disease in mother   |
| O35.4xx+  | Maternal care for (suspected) damage to fetus from alcohol   |
| O35.5xx+  | Maternal care for (suspected) damage to fetus by drugs   |
| O35.6xx+  | Maternal care for (suspected) damage to fetus by radiation   |
| O35.8xx+  | Maternal care for other (suspected) fetal abnormality and damage   |
| O35.9xx+  | Maternal care for (suspected) fetal abnormality and damage, unspecified  |
| O36.011+ - O36.099+   | Maternal care for rhesus isoimmunization   |
| O36.111+ - O36.199+   | Maternal care for other isoimmunization  |
| O36.511+ - O36.599+   | Maternal care for other known or suspected poor fetal growth   |
| O40.1xx+ - O40.9xx+   | Polyhydramnios   |
| O41.00x+ - O41.03x+   | Oligohydramnios  |
| O69.81x+ - O69.89x+   | Labor and delivery complicated by other cord complications   |
| O71.9   | Obstetric trauma, unspecified  |
| O76   | Abnormality in fetal heart rate and rhythm complicating labor and delivery   |
| O98.311 – O98.319,<br>O98.411 – O98.419,<br>O98.511 – O98.519,<br>O98.611 – O98.619,<br>O98.711 – O98.719,<br>O98.811 – O98.819 | Other maternal infectious and parasitic diseases complicating pregnancy  |
| O99.320 – O99.323   | Drug use complicating pregnancy  |
| O99.411 – O99.419   | Diseases of the circulatory system complicating pregnancy  |
| Q04.8   | Other specified congenital malformations of brain [choroid plexus cyst]  |
| Q30.1   | Agenesis and underdevelopment of nose [absent or hypoplastic nasal bone]   |
| Q62.0   | Congenital hydronephrosis [fetal pyelectasis]  |
| Q71.811 – Q71.819   | Congenital shortening of upper limb [humerus]  |
| Q72.811 – Q72.819   | Congenital shortening of lower limb [femur]  |
| Q92.0 – Q92.9   | Other trisomies and partial trisomies of the autosomes, not elsewhere classified [fetuses with soft sonographic markers of aneuploidy] |
| R93.5   | Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum  |
| R93.8   | Abnormal findings on diagnostic imaging of other specified body structures   |
| Z68.35 – Z68.45   | Body mass index (BMI) 35.0 – 70 or greater, adult  |

| <b>Reviews, Revisions, and Approvals</b>  | <b>Date</b> | <b>Approval Date</b> |
|---|-------------|----------------------|
| Policy created & reviewed by Obstetrical specialist   | 01/11       | 01/11                |
| Reviewed with no changes<br>Obstetrical specialist reviewed   | 02/12       | 03/12                |
| Reviewed with no changes  | 04/13       | 05/13                |
| Nuchal translucency removed<br>Divided criteria into first and second trimester<br>Added indications for transvaginal ultrasound<br>Obstetrical specialist reviewed   | 05/14       | 08/14                |
| Reformatted policy<br>Added ICD-9 and ICD-10 codes for when a standard ultrasound would be appropriate<br>Obstetrical specialist reviewed<br>Removed prior authorization language   | 08/15       | 08/15                |
| Removed ICD-9 codes   | 11/15       |                      |
| Added follow-up ultrasound as an alternative in Policy/Criteria sections I and II   | 02/16       |                      |
| Reviewed with no criteria changes.  | 08/16       | 08/16                |
| Allowed up to 6 TVU per pregnancy and added ICD-10 codes indicating when > 6 TVUs are appropriate   | 11/16       |                      |
| Added to ICD-10 code list for standard ultrasounds: O02.0 – O02.9, O03.9, O28.0 – O28.9, Z32.01   | 01/17       |                      |
| Removed ICD-10 code tables for 76801 and 76805, and 76817 No diagnosis code limitations in place for these codes. 76817 frequency over time changed to 12 from 6  | 05/17       |                      |
| Added that transperineal u/s can be appropriate for a standard first trimester ultrasound scan per updated ACOG guidelines. Added “possibility of fetal growth restriction and multifetal gestation” to indications for detailed ultrasound in section III. Added “as an adjunct to embryo transfer” as an indication for standard first trimester ultrasound in “classifications of fetal ultrasound” section I. Added “The maternal cervix and adnexa are examined as clinically appropriate and when feasible” to description of standard second or third trimester ultrasound in “classifications of fetal ultrasound” section II. Minor wording clarifications made to criteria throughout policy to ensure consistency with latest ACOG practice bulletin for Ultrasound in Pregnancy, No. 175. | 08/17       | 08/17                |
| Removed – in the primary diagnosis position from section III as this is not a requirement for the edit.   | 12/17       |                      |
| Added code range O30.801 – O30.899 to Table 4. References reviewed and updated.   | 06/18       | 06/18                |

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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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## CLINICAL POLICY

### Ultrasound in Pregnancy

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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# CONFIDENTIAL MORBIDITY REPORT

**PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.**

**DISEASE BEING REPORTED** ➔

|   |  |  |  |  |  |   |
|---|--|--|--|--|--|---|
| <b>Patient Name - Last Name</b>   |  | <b>First Name</b>  |  | <b>MI</b>  | <b>Ethnicity (check one)</b><br><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown |   |
| <b>Home Address: Number, Street</b>   |  |  |  | <b>Apt./Unit No.</b>   |  |   |
| <b>City</b>   |  |  | <b>State</b>   | <b>ZIP Code</b>  |  |   |
| <b>Home Telephone Number</b>  |  | <b>Cell Telephone Number</b>   |  | <b>Work Telephone Number</b>   |  |   |
| <b>Email Address</b>  |  |  | <b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish<br><input type="checkbox"/> Other: _____ |  |  |   |
| <b>Birth Date (mm/dd/yyyy)</b>  |  | <b>Age</b>   |  | <b>Gender</b>  |  |   |
|   |  | <input type="checkbox"/> Years<br><input type="checkbox"/> Months<br><input type="checkbox"/> Days |  | <input type="checkbox"/> M to F Transgender<br><input type="checkbox"/> Male <input type="checkbox"/> F to M Transgender<br><input type="checkbox"/> Female <input type="checkbox"/> Other: _____  |  |   |
| <b>Pregnant?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  | <b>Est. Delivery Date (mm/dd/yyyy)</b>   |  | <b>Country of Birth</b>  |  |   |
| <b>Occupation or Job Title</b>  |  |  |  | <b>Occupational or Exposure Setting (check all that apply):</b> <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care<br><input type="checkbox"/> Correctional Facility <input type="checkbox"/> School <input type="checkbox"/> Other (specify): _____ |  |   |
| <b>Date of Onset (mm/dd/yyyy)</b>   |  | <b>Date of First Specimen Collection (mm/dd/yyyy)</b>  |  | <b>Date of Diagnosis (mm/dd/yyyy)</b>  |  | <b>Date of Death (mm/dd/yyyy)</b>   |
| <b>Reporting Health Care Provider</b>   |  |  | <b>Reporting Health Care Facility</b>  |  |  | <b>REPORT TO:</b><br><br><br><br><br><br><br><br><br><br><br>(Obtain additional forms from your local health department.) |
| <b>Address: Number, Street</b>  |  |  |  | <b>Suite/Unit No.</b>  |  |   |
| <b>City</b>   |  |  | <b>State</b>   | <b>ZIP Code</b>  |  |   |
| <b>Telephone Number</b>   |  | <b>Fax Number</b>  |  |  |  |   |
| <b>Submitted by</b>   |  |  | <b>Date Submitted (mm/dd/yyyy)</b>   |  |  |   |
| <b>Laboratory Name</b>  |  |  |  | <b>City</b>  | <b>State</b>   | <b>ZIP Code</b>   |

| SEXUALLY TRANSMITTED DISEASES (STDs)  |                              |   |              |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
|---|------------------------------|---|--------------|------------------------------|------------------------------|------------------------------|--------------|-------------------------------|------------------------------|------------------------------|-------|----------------------------------|------------------------------|------------------------------|-------|--------------------------------|------------------------------|------------------------------|-------|-----------------------------------|------------------------------|------------------------------|-------|-----------------------------------|------------------------------|------------------------------|-------|---------------------------------------|--|--|--|
| <b>Gender of Sex Partners (check all that apply)</b><br><input type="checkbox"/> Male <input type="checkbox"/> M to F Transgender<br><input type="checkbox"/> Female <input type="checkbox"/> F to M Transgender<br><input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____  |                              | <b>STD TREATMENT</b> <input type="checkbox"/> Treated in office <input type="checkbox"/> Given prescription<br><b>Drug(s), Dosage, Route</b><br>_____<br>_____  |              |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
|   |                              | <b>Treatment Began (mm/dd/yyyy)</b> <input type="checkbox"/> <b>Untreated</b><br><input type="checkbox"/> Will treat<br><input type="checkbox"/> Unable to contact patient<br><input type="checkbox"/> Patient refused treatment<br><input type="checkbox"/> Referred to: _____   |              |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <b>If reporting Syphilis, Stage:</b><br><input type="checkbox"/> Primary (lesion present)<br><input type="checkbox"/> Secondary<br><input type="checkbox"/> Early latent < 1 year<br><input type="checkbox"/> Latent (unknown duration)<br><input type="checkbox"/> Late latent > 1 year<br><input type="checkbox"/> Late (tertiary)<br><input type="checkbox"/> Congenital<br><b>Neurosyphilis?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                              | <b>Syphilis Test Results</b><br><table style="width: 100%;"> <tr> <td><input type="checkbox"/> RPR</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td>Titer: _____</td> </tr> <tr> <td><input type="checkbox"/> VDRL</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> FTA-ABS</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> TP-PA</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> EIA/CLIA</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> CSF-VDRL</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td>_____</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Other: _____</td> </tr> </table> |              | <input type="checkbox"/> RPR | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | Titer: _____ | <input type="checkbox"/> VDRL | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | _____ | <input type="checkbox"/> FTA-ABS | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | _____ | <input type="checkbox"/> TP-PA | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | _____ | <input type="checkbox"/> EIA/CLIA | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | _____ | <input type="checkbox"/> CSF-VDRL | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | _____ | <input type="checkbox"/> Other: _____ |  |  |  |
| <input type="checkbox"/> RPR  | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg  | Titer: _____ |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <input type="checkbox"/> VDRL   | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg  | _____        |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <input type="checkbox"/> FTA-ABS  | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg  | _____        |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <input type="checkbox"/> TP-PA  | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg  | _____        |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <input type="checkbox"/> EIA/CLIA   | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg  | _____        |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <input type="checkbox"/> CSF-VDRL   | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg  | _____        |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <input type="checkbox"/> Other: _____   |                              |   |              |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |
| <b>If reporting Chlamydia and/or Gonorrhea:</b><br><b>Specimen Source(s) (check all that apply)</b><br><input type="checkbox"/> Cervical<br><input type="checkbox"/> Pharyngeal<br><input type="checkbox"/> Rectal<br><input type="checkbox"/> Urethral<br><input type="checkbox"/> Urine<br><input type="checkbox"/> Vaginal<br><input type="checkbox"/> Other: _____  |                              | <b>If reporting Pelvic Inflammatory Disease: (check all that apply)</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Gonococcal PID<br><input type="checkbox"/> Chlamydial PID<br><input type="checkbox"/> Other/Unknown Etiology PID<br><br><b>Partner(s) Treated?</b><br><input type="checkbox"/> Yes, treated in this clinic <input type="checkbox"/> No, instructed patient to refer partner(s) for treatment<br><input type="checkbox"/> Yes, Meds/Prescription given to patient for their partner(s) <input type="checkbox"/> No, referred partner(s) to: _____<br><input type="checkbox"/> Yes, other: _____ <input type="checkbox"/> Unknown   |              |                              |                              |                              |              |                               |                              |                              |       |                                  |                              |                              |       |                                |                              |                              |       |                                   |                              |                              |       |                                   |                              |                              |       |                                       |  |  |  |

| VIRAL HEPATITIS   |                          |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
|---|--------------------------|--|-----------------------|--------------------------|--------------------------|---------------|--|------------|--------------------|---------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|--|--|--|----------|--------------------------|--------------------------|--|--|--|----------------|--|--|--|--|--|
| <b>Diagnosis (check all that apply)</b><br><input type="checkbox"/> Hepatitis A<br><input type="checkbox"/> Hepatitis B (acute)<br><input type="checkbox"/> Hepatitis B (chronic)<br><input type="checkbox"/> Hepatitis B (perinatal)<br><input type="checkbox"/> Hepatitis C (acute)<br><input type="checkbox"/> Hepatitis C (chronic)<br><input type="checkbox"/> Hepatitis D<br><input type="checkbox"/> Hepatitis E |                          | <b>Is patient symptomatic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| <b>Suspected Exposure Type(s)</b><br><input type="checkbox"/> Blood transfusion, dental or medical procedure<br><input type="checkbox"/> IV drug use<br><input type="checkbox"/> Other needle exposure<br><input type="checkbox"/> Sexual contact<br><input type="checkbox"/> Household contact<br><input type="checkbox"/> Perinatal<br><input type="checkbox"/> Child care<br><input type="checkbox"/> Other: _____   |                          | <table style="width: 100%;"> <tr> <td>ALT (SGPT)</td> <td>Upper Limit: _____</td> </tr> <tr> <td>Result: _____</td> <td></td> </tr> <tr> <td>AST (SGOT)</td> <td>Upper Limit: _____</td> </tr> <tr> <td>Result: _____</td> <td></td> </tr> <tr> <td>Bilirubin result: _____</td> <td></td> </tr> </table>  |                       | ALT (SGPT)               | Upper Limit: _____       | Result: _____ |  | AST (SGOT) | Upper Limit: _____ | Result: _____             |                          | Bilirubin result: _____  |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| ALT (SGPT)  | Upper Limit: _____       |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| Result: _____   |                          |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| AST (SGOT)  | Upper Limit: _____       |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| Result: _____   |                          |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| Bilirubin result: _____   |                          |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
|   |                          | <table style="width: 100%;"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th></th> <th>Pos</th> <th>Neg</th> </tr> </thead> <tbody> <tr> <td><b>Hep A</b> anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Hep C</b> anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>Hep B</b> HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBc total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HCV RNA (e.g., PCR)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Hep D</b> anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Hep E</b> anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HBeAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HBV DNA: _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |                       |                          | Pos                      | Neg           |  | Pos        | Neg                | <b>Hep A</b> anti-HAV IgM | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hep C</b> anti-HCV | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hep B</b> HBsAg | <input type="checkbox"/> | <input type="checkbox"/> | RIBA | <input type="checkbox"/> | <input type="checkbox"/> | anti-HBc total | <input type="checkbox"/> | <input type="checkbox"/> | HCV RNA (e.g., PCR) | <input type="checkbox"/> | <input type="checkbox"/> | anti-HBc IgM | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hep D</b> anti-HDV | <input type="checkbox"/> | <input type="checkbox"/> | anti-HBs | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hep E</b> anti-HEV | <input type="checkbox"/> | <input type="checkbox"/> | HBeAg | <input type="checkbox"/> | <input type="checkbox"/> |  |  |  | anti-HBe | <input type="checkbox"/> | <input type="checkbox"/> |  |  |  | HBV DNA: _____ |  |  |  |  |  |
|   | Pos                      | Neg  |                       | Pos                      | Neg                      |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| <b>Hep A</b> anti-HAV IgM   | <input type="checkbox"/> | <input type="checkbox"/>   | <b>Hep C</b> anti-HCV | <input type="checkbox"/> | <input type="checkbox"/> |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| <b>Hep B</b> HBsAg  | <input type="checkbox"/> | <input type="checkbox"/>   | RIBA                  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| anti-HBc total  | <input type="checkbox"/> | <input type="checkbox"/>   | HCV RNA (e.g., PCR)   | <input type="checkbox"/> | <input type="checkbox"/> |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| anti-HBc IgM  | <input type="checkbox"/> | <input type="checkbox"/>   | <b>Hep D</b> anti-HDV | <input type="checkbox"/> | <input type="checkbox"/> |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| anti-HBs  | <input type="checkbox"/> | <input type="checkbox"/>   | <b>Hep E</b> anti-HEV | <input type="checkbox"/> | <input type="checkbox"/> |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| HBeAg   | <input type="checkbox"/> | <input type="checkbox"/>   |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| anti-HBe  | <input type="checkbox"/> | <input type="checkbox"/>   |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |
| HBV DNA: _____  |                          |  |                       |                          |                          |               |  |            |                    |                           |                          |                          |                       |                          |                          |                    |                          |                          |      |                          |                          |                |                          |                          |                     |                          |                          |              |                          |                          |                       |                          |                          |          |                          |                          |                       |                          |                          |       |                          |                          |  |  |  |          |                          |                          |  |  |  |                |  |  |  |  |  |

**Remarks:**

**Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions\***

**§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

**URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]**

- Ⓢ ! = Report immediately by telephone (designated by a ♦ in regulations).
- † = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
- FAX Ⓢ Ⓢ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
- = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

**REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)**

|   |  |
|---|--|
| <p>Acquired Immune Deficiency Syndrome (AIDS)<br/>(HIV infection only: see "Human Immunodeficiency Virus")</p> <p>FAX Ⓢ Ⓢ Arnebiasis</p> <p>Ⓢ ! Anaplasmosis/Ehrlichiosis</p> <p>FAX Ⓢ Ⓢ Ⓢ Anthrax, human or animal</p> <p>Ⓢ ! Babesiosis</p> <p>Ⓢ ! Botulism (Infant, Foodborne, Wound, Other)</p> <p>Ⓢ ! Brucellosis, animal (except infections due to <i>Brucella canis</i>)</p> <p>Ⓢ ! Brucellosis, human</p> <p>FAX Ⓢ Ⓢ Campylobacteriosis</p> <p>Chancroid</p> <p>FAX Ⓢ Ⓢ Chickenpox (Varicella) (only hospitalizations and deaths)</p> <p><i>Chlamydia trachomatis</i> infections, including lymphogranuloma venereum (LGV)</p> <p>Ⓢ ! Cholera</p> <p>Ⓢ ! Ciguatera Fish Poisoning</p> <p>Coccidioidomycosis</p> <p>Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</p> <p>FAX Ⓢ Ⓢ Cryptosporidiosis</p> <p>Cyclosporiasis</p> <p>Cysticercosis or taeniasis</p> <p>Ⓢ ! Dengue</p> <p>Ⓢ ! Diphtheria</p> <p>Ⓢ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>FAX Ⓢ Ⓢ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>Ⓢ ! <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli</i> O157</p> <p>† FAX Ⓢ Ⓢ Foodborne Disease</p> <p>Giardiasis</p> <p>Gonococcal Infections</p> <p>FAX Ⓢ Ⓢ <i>Haemophilus influenzae</i>, invasive disease (report an incident of less than 15 years of age)</p> <p>Ⓢ ! Hantavirus Infections</p> <p>Ⓢ ! Hemolytic Uremic Syndrome</p> <p>FAX Ⓢ Ⓢ Hepatitis A, acute infection</p> <p>Hepatitis B (specify acute case or chronic)</p> <p>Hepatitis C (specify acute case or chronic)</p> <p>Hepatitis D (Delta) (specify acute case or chronic)</p> <p>Hepatitis E, acute infection</p> <p>Influenza, deaths in laboratory-confirmed cases for age 0-64 years</p> <p>Ⓢ ! Influenza, novel strains (human)</p> <p>Legionellosis</p> <p>Leprosy (Hansen Disease)</p> <p>Leptospirosis</p> <p>FAX Ⓢ Ⓢ Listeriosis</p> <p>Lyme Disease</p> <p>FAX Ⓢ Ⓢ Malaria</p> <p>Ⓢ ! Measles (Rubeola)</p> <p>FAX Ⓢ Ⓢ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>Ⓢ ! Meningococcal Infections</p> <p>Mumps</p> <p>Ⓢ ! Paralytic Shellfish Poisoning</p> <p>Pelvic Inflammatory Disease (PID)</p> <p>FAX Ⓢ Ⓢ Pertussis (Whooping Cough)</p> <p>Ⓢ ! Plague, human or animal</p> <p>FAX Ⓢ Ⓢ Poliovirus Infection</p> <p>FAX Ⓢ Ⓢ Psittacosis</p> | <p>FAX Ⓢ Ⓢ Q Fever</p> <p>Ⓢ ! Rabies, human or animal</p> <p>FAX Ⓢ Ⓢ Relapsing Fever</p> <p>Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses</p> <p>Rocky Mountain Spotted Fever</p> <p>Rubella (German Measles)</p> <p>Rubella Syndrome, Congenital</p> <p>FAX Ⓢ Ⓢ Salmonellosis (Other than Typhoid Fever)</p> <p>Ⓢ ! Scombroid Fish Poisoning</p> <p>Ⓢ ! Severe Acute Respiratory Syndrome (SARS)</p> <p>Ⓢ ! Shiga toxin (detected in feces)</p> <p>FAX Ⓢ Ⓢ Shigellosis</p> <p>Ⓢ ! Smallpox (Variola)</p> <p>FAX Ⓢ Ⓢ <i>Staphylococcus aureus</i> infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)</p> <p>FAX Ⓢ Ⓢ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</p> <p>FAX Ⓢ Ⓢ Syphilis</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>FAX Ⓢ Ⓢ Trichinosis</p> <p>FAX Ⓢ Ⓢ Tuberculosis</p> <p>Tularemia, animal</p> <p>Ⓢ ! Tularemia, human</p> <p>FAX Ⓢ Ⓢ Typhoid Fever, Cases and Carriers</p> <p>FAX Ⓢ Ⓢ <i>Vibrio</i> Infections</p> <p>Ⓢ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)</p> <p>FAX Ⓢ Ⓢ West Nile virus (WNV) Infection</p> <p>Ⓢ ! Yellow Fever</p> <p>FAX Ⓢ Ⓢ Yersiniosis</p> <p>Ⓢ ! OCCURRENCE of ANY UNUSUAL DISEASE</p> <p>Ⓢ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.</p> |
|---|--|

**HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20**

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and <http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx>

**REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800-2812 and §2593(b)**

Disorders Characterized by Lapses of Consciousness (§2800-2812)  
 Pesticide-related illness or injury (known or suspected cases)\*\*  
 Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)\*\*\*

**LOCALLY REPORTABLE DISEASES (If Applicable):**

\* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

\*\* Failure to report is a citable offense and subject to civil penalty (§250) (Health and Safety Code §105200).

\*\*\* The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: [www.ccrca.org](http://www.ccrca.org).



## Referral to Health Net Fax Form

- California – HMO/Point-of-Service (POS)/HSP, EPO, PPO, Medicare Advantage (MA) HMO

Decision Power® clinicians are available 24 hours a day, 365 days a year to provide education and support to eligible Health Net members who have chronic conditions. **To refer a patient to Health Net’s Decision Power Disease Management or Wellness programs, please complete this form and fax it to Decision Power at 1-800-451-4730. Note: Do not mail this completed form; fax only please.**

### Provider Information:

|                             |  |
|-----------------------------|--|
| <b>Name:</b>                |  |
| <b>Office telephone:</b>    |  |
| <b>Email address:</b>       |  |
| <b>Date of referral:</b>    |  |
| <b>Reason for referral:</b> |  |

### Member Information:

| First and Last Name | Subscriber ID # | Gender | DOB | Telephone # | Program Referred For |
|---------------------|-----------------|--------|-----|-------------|----------------------|
|                     |                 |        |     |             |                      |
|                     |                 |        |     |             |                      |
|                     |                 |        |     |             |                      |

### Referrals are accepted for the following:

#### Targeted disease management conditions

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Heart Failure (HF)

#### Types of Support

- Adherence to treatment plan
- Gap closure
- High-risk chronic condition management
- Medication persistence
- Nutrition/lifestyle changes

#### Lifestyle programs

- Quit For Life™ (tobacco cessation)
- Wellness Health Coaching (weight loss, stress management, exercise and/or healthy eating)

**Note: This form should not be used to refer Medi-Cal members.**

**\*For case management needs, please refer to the Healthcare Services Department Case Management Referral Form, available in the Forms section of the Provider Library on the Health Net provider website at [provider.healthnet.com](http://provider.healthnet.com), and fax to 1-800-745-6955.**

Enrollees have access to Decision Power through their current enrollment with any health plan offered by the following Health Net, LLC-affiliated companies: Health Net of California, Inc. and Health Net Life Insurance Company. Decision Power is not part of Health Net’s medical benefit plans. Decision Power services, including clinicians are additional resources that Health Net makes available to enrollees. Decision Power is not affiliated with Health Net’s provider network. Decision Power services are not subject to the Medicare appeals process. Disputes regarding products and services may be subject to Health Net’s grievance process. Health Net, LLC may revise or withdraw the availability of Decision Power without notice. Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net and Decision Power are registered service marks of Health Net, LLC. All rights reserved.



# COMPLETE CODE LIST

The Lists are in Numerical Order and divided by Modality below:

## CT/CTA

CT - Computed Tomography

CTA - Computed Tomography Angiography

## MRI/MRA

MRI - Magnetic Resonance Imaging

MRA - Magnetic Resonance Angiography

NOTE: NCM-MPI-MUGA included for HNCA HMO members starting 1-1-14

## NCM – MPI – MUGA

Nuclear Cardiac Medicine (NCM)

Myocardial Perfusion Imaging(MPI)

MUGA, [aka: Blood Pool Imaging]

## PET & PET/CT

PET and PET/CT - Positron Emission Tomography

## 3D RENDERING

## SLEEP STUDIES

**HNCA CODE LISTS - By Modality and In Numerical Order****CT - Computed Tomography**

|              |   |              |                                   |
|--------------|---|--------------|-----------------------------------|
| <b>0042T</b> | Cerebral perfusion analysis using CT with contrast administration,  |              |                                   |
| <b>70450</b> | CT Head without contrast  | <b>70460</b> | CT Head with contrast             |
| <b>70470</b> | CT Head with & without contrast W & W/O   |              |                                   |
| <b>70480</b> | CT Orbit, sella, or posterior fossa or outer, middle, or inner ear W/O  |              |                                   |
| <b>70481</b> | CT Orbit, sella, or posterior fossa or outer, middle, or inner ear with contrast  |              |                                   |
| <b>70482</b> | CT Orbit, sella, or posterior fossa or outer, middle, or inner ear W & W/O  |              |                                   |
| <b>70486</b> | CT Maxillofacial area, (sinus) without contrast   |              |                                   |
| <b>70487</b> | CT Maxillofacial area, (sinus) with contrast  |              |                                   |
| <b>70488</b> | CT Maxillofacial area, (sinus) with & without contrast W & W/O  |              |                                   |
| <b>70490</b> | CT Soft-tissue Neck W/O   | <b>70491</b> | CT Soft-tissue Neck with contrast |
| <b>70492</b> | CT Soft-tissue Neck with & without contrast W & W/O   |              |                                   |
| <b>71250</b> | CT Chest without contrast   | <b>71260</b> | CT Chest with contrast            |
| <b>71270</b> | CT Chest with and without contrast W & W/O  |              |                                   |
| <b>72125</b> | CT Cervical Spine W/O   | <b>72126</b> | CT Cervical Spine with contrast   |
| <b>72127</b> | CT Cervical Spine with and without contrast W & W/O   |              |                                   |
| <b>72128</b> | CT Thoracic Spine W/O   | <b>72129</b> | CT Thoracic Spine with contrast   |
| <b>72130</b> | CT Thoracic Spine with and without contrast W & W/O   |              |                                   |
| <b>72131</b> | CT Lumbar Spine W/O   | <b>72132</b> | CT Lumbar Spine with contrast     |
| <b>72133</b> | CT Lumbar Spine with and without out contrast W & W/O   |              |                                   |
| <b>72192</b> | CT Pelvis W/O   | <b>72193</b> | CT Pelvis with contrast           |
| <b>72194</b> | CT Pelvis with and without contrast W & W/O   |              |                                   |
| <b>73200</b> | CT Upper Extremity W/O  | <b>73201</b> | CT Upper Extremity with contrast  |
| <b>73202</b> | CT Upper Extremity with and without contrast W & W/O  |              |                                   |
| <b>73700</b> | CT Lower Extremity W/O  | <b>73701</b> | CT Lower Extremity with contrast  |
| <b>73702</b> | CT Lower Extremity with and without contrast W & W/O  |              |                                   |
| <b>74150</b> | CT Abdomen W/O  | <b>74160</b> | CT Abdomen with contrast          |
| <b>74170</b> | CT Abdomen with and without contrast W & W/O  |              |                                   |
| <b>74176</b> | CT ABDOMEN and PELVIS; without contrast   |              |                                   |
| <b>74177</b> | CT ABDOMEN and PELVIS; with contrast  |              |                                   |
| <b>74178</b> | CT ABDOMEN and PELVIS; with & without contrast  |              |                                   |
| <b>74261</b> | CT Colonography, diagnostic; without contrast material  |              |                                   |
| <b>74262</b> | CT Colonography, diagnostic; with contrast material   |              |                                   |
| <b>74263</b> | CT Colonography, screening, including image postprocessing  |              |                                   |
| <b>75571</b> | CT, HEART, without contrast with quantitative evaluation of coronary calcium  |              |                                   |
| <b>75572</b> | CT, heart, with contrast, for evaluation of cardiac structure and morphology  |              |                                   |
| <b>75573</b> | CT, heart, with contrast, for evaluation of cardiac structure and morphology in the setting of congenital heart disease   |              |                                   |
| <b>75574</b> | CT, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing |              |                                   |
| <b>76380</b> | CT Limited or Localized follow-up   |              |                                   |
| <b>76497</b> | Unlisted CT procedure (e.g., diagnostic, interventional)  |              |                                   |
| <b>77078</b> | CT BONE MINERAL DENSITY study, 1 or more sites, axial skeleton  |              |                                   |
| <b>S8092</b> | CT ELECTRON BEAM (also known as Ultrafast CT, Cine CT)  |              |                                   |

[RETURN](#)



**HNCA CODE LISTS - By Modality and In Numerical Order**

**CTA - Computed Tomographic Angiography**

|              |   |
|--------------|---|
| <b>70496</b> | CT Angiography (CTA), Head- includes post-processing                                  |
| <b>70498</b> | CT Angiography (CTA), Neck-includes post-processing                                   |
| <b>71275</b> | CT Angiography (CTA), Chest ( <u>NON-CORONARY</u> ) includes post-processing          |
| <b>72191</b> | CT Angiography (CTA) Pelvis-includes post-processing                                  |
| <b>73206</b> | CT Angiography (CTA) Upper Extremity-includes post-processing                         |
| <b>73706</b> | CT Angiography (CTA) Lower Extremity- includes post-processing                        |
| <b>74174</b> | CT Angiography (CTA) Abdomen and Pelvis- W & W/O includes post-processing             |
| <b>74175</b> | CT Angiography (CTA) Abdomen- W & W/O includes post-processing                        |
| <b>75635</b> | CT Angiography (CTA) Abdominal Aorta and bilateral iliofemoral lower extremity runoff |

**MRI – Magnetic Resonance Imaging**

|              |   |              |  |
|--------------|---|--------------|--|
| <b>0159T</b> | CAD for BREAST MRI  | <b>70336</b> | MRI Temporomandibular Joint(s) TMJ           |
| <b>70540</b> | MRI Orbit, Face and/or Neck W/O   | <b>70542</b> | MRI Orbit, Face and/or Neck with contrast    |
| <b>70543</b> | MRI Orbit, Face and/or Neck with and without contrast W & W/O                           |              |  |
| <b>70551</b> | MRI Brain (Head) W/O  | <b>70552</b> | MRI Brain (Head) with contrast               |
| <b>70553</b> | MRI Brain (Head) with and without contrast W & W/O                                      |              |  |
| <b>70554</b> | MRI Brain, <b>functional MRI</b> ; not requiring physician or psychologist              |              |  |
| <b>70555</b> | MRI, Brain, <b>functional MRI</b> ; requiring physician or psychologist                 |              |  |
| <b>71550</b> | MRI Chest W/O   | <b>71551</b> | MRI Chest with contrast                      |
| <b>71552</b> | MRI Chest with and without contrast W & W/O   |              |  |
| <b>72141</b> | MRI Cervical Spine W/O  | <b>72142</b> | MRI Cervical Spine with contrast             |
| <b>72146</b> | MRI Thoracic Spine W/O  | <b>72147</b> | MRI Thoracic Spine with contrast             |
| <b>72148</b> | MRI Lumbar Spine W/O  | <b>72149</b> | MRI Lumbar Spine with contrast               |
| <b>72156</b> | MRI Cervical Spine with and without contrast W & W/O                                    |              |  |
| <b>72157</b> | MRI Thoracic Spine with and without contrast W & W/O                                    |              |  |
| <b>72158</b> | MRI Lumbar Spine with and without contrast W & W/O                                      |              |  |
| <b>72195</b> | MRI Pelvis W/O  | <b>72196</b> | MRI Pelvis with contrast                     |
| <b>72197</b> | MRI Pelvis with and without contrast W & W/O  |              |  |
| <b>73218</b> | MRI Upper Extremity- <i>other than joint</i> -without contrast                          |              |  |
| <b>73219</b> | MRI Upper Extremity- <i>other than joint</i> -with contrast                             |              |  |
| <b>73220</b> | MRI Upper Extremity- <i>other than joint</i> -with and without contrast W & W/O         |              |  |
| <b>73221</b> | MRI Any Joint Upper Extremity W/O   | <b>73222</b> | MRI Any Joint Upper Extremity--with contrast |
| <b>73223</b> | MRI Any Joint of Upper Extremity—with and without contrast W & W/O                      |              |  |
| <b>73718</b> | MRI Lower Extremity- <i>other than joint</i> -without contrast                          |              |  |
| <b>73719</b> | MRI Lower Extremity- <i>other than joint</i> -with contrast                             |              |  |
| <b>73720</b> | MRI Lower Extremity- <i>other than joint</i> -with and without contrast W & W/O         |              |  |
| <b>73721</b> | MRI Any Joint of Lower Extremity W/O  | <b>73722</b> | MRI Any Joint of Lower Extremity--with       |
| <b>73723</b> | MRI Any Joint of Lower Extremity—with and without contrast W & W/O                      |              |  |
| <b>74181</b> | MRI Abdomen W/O   | <b>74182</b> | MRI Abdomen with contrast                    |
| <b>74183</b> | MRI Abdomen with and without contrast W & W/O   |              |  |
| <b>75557</b> | Cardiac MRI for morphology and function without contrast materials                      |              |  |
| <b>75559</b> | Cardiac MRI for morphology and function without contrast materials; with stress imaging |              |  |
| <b>75561</b> | Cardiac MRI for morphology and function WO, followed by contrast                        |              |  |
| <b>75563</b> | Cardiac MRI for morphology and function WO, followed by contrast; with stress imaging   |              |  |
| <b>75565</b> | Cardiac magnetic resonance imaging for velocity flow mapping (List separately)          |              |  |
| <b>76390</b> | MR Spectroscopy (MRS)   |              |  |
| <b>76498</b> | Unlisted MR procedure (eg, diagnostic, interventional)                                  |              |  |
| <b>77058</b> | MRI BREAST, UNILATERAL  | <b>77059</b> | MRI BREAST, BILATERAL                        |

[RETURN](#)

**HNCA CODE LISTS - By Modality and In Numerical Order**

**MRI – Magnetic Resonance Imaging**

|              |  |
|--------------|--|
| <b>77084</b> | MRI Bone Marrow blood supply                       |
| <b>S8035</b> | Magnetic source imaging                            |
| <b>S8037</b> | MRCP (Magnetic Resonance Cholangiopancreatography) |
| <b>S8042</b> | MRI Low-Field                                      |

**MRA – Magnetic Resonance Angiography**

|              |  |              |                        |
|--------------|--|--------------|------------------------|
| <b>70544</b> | MRA Head without contrast  | <b>70545</b> | MRA Head with contrast |
| <b>70546</b> | MR Angiography (MRA) Head with and without contrast W & W/O        |              |                        |
| <b>70547</b> | MRA Neck without contrast  | <b>70548</b> | MRA Neck with contrast |
| <b>70549</b> | MR Angiography (MRA) Neck with and without contrast W & W/O        |              |                        |
| <b>71555</b> | MR Angiography (MRA) Chest (excluding myocardium)- W <u>or</u> W/O |              |                        |
| <b>72159</b> | MR Angiography (MRA) Spinal Canal and contents                     |              |                        |
| <b>72198</b> | MR Angiography (MRA) Pelvis -with or without contrast              |              |                        |
| <b>73225</b> | MR Angiography (MRA) Upper Extremity -with or without contrast     |              |                        |
| <b>73725</b> | MR Angiography (MRA) Lower Extremity-with or without contrast      |              |                        |
| <b>74185</b> | MR Angiography (MRA) Abdomen-with or without contrast              |              |                        |

**MPI – Myocardial Perfusion Imaging**

**NCM – Nuclear Cardiac Imaging**

|              |   |
|--------------|---|
| <b>78451</b> | Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative <b>wall motion, ejection fraction</b> by first pass or gated technique, additional quantification, when performed); <b>single study, at rest or stress</b>         |
| <b>78452</b> | Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative <b>wall motion, ejection fraction</b> by first pass or gated technique, additional quantification, when performed); <b>multiple studies, at rest and/or stress</b> |
| <b>78453</b> | Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); <b>single study, at rest or stress</b>   |
| <b>78454</b> | Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); <b>multiple studies, at rest and/or stress</b>   |
| <b>78466</b> | Myocardial Imaging, infarct avid, planar; qualitative or quantitative   |
| <b>78468</b> | Myocardial Imaging, infarct avid, planar; w/ EF by first pass technique   |
| <b>78469</b> | Myocardial Imaging, infarct avid, planar; tomographic SPECT   |
| <b>78472</b> | Cardiac Blood Pool imaging, gated equilibrium; planar, single study at rest <b>or</b> stress  |
| <b>78473</b> | Cardiac Blood Pool imaging, multiple studies, at rest <b>and</b> stress,  |
| <b>78481</b> | Cardiac Blood Pool imaging, (planar), first pass technique; single study, at rest or with stress  |
| <b>78483</b> | Cardiac Blood Pool imaging, (planar), first pass technique; multiple studies at rest and stress   |
| <b>78494</b> | Cardiac Blood Pool imaging, gated equilibrium, SPECT  |
| <b>78496</b> | Cardiac Blood Pool imaging, gated equilibrium, RV EF by first pass  |
| <b>78499</b> | Unlisted cardiovascular procedure, diagnostic nuclear medicine  |

[RETURN](#)

**HNCA CODE LISTS - By Modality and In Numerical Order**

**PET and PET/CT - Positron Emission Tomography**

|              |  |              |   |
|--------------|--|--------------|---|
| <b>78608</b> | PET Brain – metabolic evaluation   | <b>78609</b> | PET Brain – perfusion evaluation              |
| <b>78459</b> | PET Cardiac–metabolic evaluation   | <b>78491</b> | PET Cardiac–perfusion, single, rest or stress |
| <b>78492</b> | PET Cardiac (myocardial imaging), perfusion multiple studies rest/stress |              |   |
| <b>78811</b> | PET Imaging; limited area (ex: chest, head/neck)                         |              |   |
| <b>78812</b> | PET Imaging; skull base to mid-thigh                                     | <b>78813</b> | PET Imaging; whole body                       |
| <b>78814</b> | PET/CT; limited area (ex: chest, head/neck)                              |              |   |
| <b>78815</b> | PET/CT; skull base to mid-thigh  | <b>78816</b> | PET/CT; whole body                            |

**3D RENDERING**

|              |  |  |  |
|--------------|--|--|--|
| <b>76376</b> | 3D rendering- <b><i>not</i></b> requiring an independent workstation |  |  |
| <b>76377</b> | 3D rendering- requiring an independent workstation                   |  |  |

**SLEEP STUDIES**

|              |  |  |  |
|--------------|--|--|--|
| <b>95800</b> | Sleep study with recording, unattended   |  |  |
| <b>95801</b> | Sleep study with recording, unattended   |  |  |
| <b>95805</b> | Sleep Study, multiple trials   |  |  |
| <b>95806</b> | Sleep study with recording, unattended   |  |  |
| <b>95807</b> | Sleep study with recording, attended by a technologist.  |  |  |
| <b>95808</b> | Polysomnography* (Type I); 1-3 additional parameters   |  |  |
| <b>95810</b> | Polysomnography* (Type I); 4 or more parameters  |  |  |
| <b>95811</b> | Polysomnography* (Type I); 4 or more parameters with airway therapy ventilation  |  |  |
| <b>95782</b> | Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist   |  |  |
| <b>95783</b> | Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist |  |  |
| <b>G0398</b> | Home sleep study test Type II  |  |  |
| <b>G0399</b> | Home sleep study test Type III   |  |  |
| <b>G0400</b> | Home sleep study test Type IV  |  |  |

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## Directory Removal for At-Risk Providers Form

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

If any of the below applies to you, please initial next to the condition that has been met in order to be omitted from the directory, and sign and date the statement at the bottom. **Please complete and submit this form via secure fax, or scan and email to following:**

| Fax number     | Email address                  |
|----------------|--------------------------------|
| 1-866-524-1286 | faxback.projects@healthnet.com |

\_\_\_\_\_ The provider is currently enrolled in the Safe at Home program ([www.sos.ca.gov/registries/safe-home](http://www.sos.ca.gov/registries/safe-home)).

\_\_\_\_\_ 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).

Group and/or provider name: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

I hereby confirm that the identified condition has been met and I should be omitted from the Health Net provider directory.

\_\_\_\_\_  
Printed name (include title if signing on behalf of a provider group or other similarly situated provider).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

Approved by OMB

0348-0046

(See reverse for public burden disclosure.)

|  |   |  |
|--|---|--|
| <b>1. Type of Federal Action:</b><br><input type="checkbox"/> a. contract<br><input type="checkbox"/> b. grant<br><input type="checkbox"/> c. cooperative agreement<br><input type="checkbox"/> d. loan<br><input type="checkbox"/> e. loan guarantee<br><input type="checkbox"/> f. loan insurance  | <b>2. Status of Federal Action:</b><br><input type="checkbox"/> a. bid/offer/application<br><input type="checkbox"/> b. initial award<br><input type="checkbox"/> c. post-award | <b>3. Report Type:</b><br><input type="checkbox"/> a. initial filing<br><input type="checkbox"/> b. material change<br><b>For Material Change Only:</b><br>year _____ quarter _____<br>date of last report _____ |
| <b>4. Name and Address of Reporting Entity:</b><br><input type="checkbox"/> Prime <input type="checkbox"/> Subawardee<br>Tier _____, <i>if known</i> :<br><br><b>Congressional District, if known:</b>   | <b>5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:</b><br><br><br><b>Congressional District, if known:</b>                                    |  |
| <b>6. Federal Department/Agency:</b>   | <b>7. Federal Program Name/Description:</b><br><br>CFDA Number, <i>if applicable</i> : _____  |  |
| <b>8. Federal Action Number, if known:</b>   | <b>9. Award Amount, if known:</b><br>\$ _____   |  |
| <b>10. a. Name and Address of Lobbying Registrant</b><br><i>(if individual, last name, first name, MI):</i>  | <b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a)</i><br><i>(last name, first name, MI):</i>   |  |
| <b>11.</b> Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure. | Signature: _____<br>Print Name: _____<br>Title: _____<br>Telephone No.: _____ Date: _____   |  |
| <b>Federal Use Only:</b>   |   | Authorized for Local Reproduction<br>Standard Form LLL (Rev. 7-97)   |

## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.







| <b>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage</b> |  |
|--|--|
| <b>Category</b>  | <b>Coding Edit</b>   |
| Ankle-foot/knee-ankle-foot orthotics   | Orthotic replacements are included in the reimbursement for orthotics  |
| Automatic external defibrillators  | External defibrillators are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*   |
| Blood glucose monitoring   | Glucose monitors/supplies are reimbursable for diabetics only and when reported with the appropriate modifier (KS or KX)   |
|  | Continuous noninvasive glucose monitors are considered experimental/investigational because the safety or efficacy of these devices have not been established by review of the available published literature  |
|  | A disposable glucose monitor is a non-covered item   |
| Breast prosthesis  | A custom breast prosthesis is reimbursed at the rate of a prefabricated breast prosthesis  |
| Canes and crutches   | When an underarm, articulating, spring-assisted crutch is provided, it is reimbursed at the rate of an underarm crutch other than wood   |
|  | Only one crutch type is covered per date of service  |
| Cervical traction devices  | Cervical traction that is free-standing or attached to a headboard is reimbursed at the rate of overdoor cervical traction   |
|  | Free-standing cervical traction is eligible for reimbursement coverage when requirements have been met and filed with the appropriate modifier.* Otherwise it is reimbursed at the rate for overdoor cervical traction   |
| Cold therapy   | A water circulating cold pad with pump is not eligible for reimbursement because it is considered investigational  |
| Commodes   | An extra wide/heavy duty commode chair is reimbursable for a member who weighs 300 pounds or more, when reported with the appropriate modifier.* It is otherwise reimbursable at the rate for a regular commode if basic coverage criteria for a commode chair are met |
|  | A commode chair with detachable arms is reimbursable when the clinical criteria are met and when it is reported with the appropriate modifier*   |
|  | A pail or pan for use with commode chair is included in the reimbursement for a commode chair  |
|  | A seat-lift mechanism is included in the reimbursement for a commode chair with a seat-lift mechanism  |

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage**

| <b>Category</b>   | <b>Coding Edit</b>   |
|---|--|
| Diabetic shoes  | Orthopedic shoes and accessories for members with diabetes are reimbursable when reported with codes specific to diabetic footwear   |
|   | An insert that is direct formed and molded to a member's foot without an external heat source is a non-covered item  |
| Enteral nutrition   | Enteral feeding supply kits are reimbursable once per day  |
|   | Additives for enteral formula are included in the reimbursement for enteral formulas   |
|   | Components of a more complete kit are included in the reimbursement for the kit  |
| External infusion pumps   | Supplies for maintaining a drug infusion catheter are not eligible for reimbursement in the same month as a drug infusion kit  |
|   | Components of a more complete kit are included in the reimbursement for the kit  |
|   | IV poles are included in the reimbursement of ambulatory infusion pumps  |
|   | Replacement batteries for an infusion pump are included in the monthly rental reimbursement of an infusion pump  |
| Hospital headboards and accessories   | Hospital bed rental is reimbursable once per month   |
|   | Hospital bed accessories that are part of the more complete hospital bed are included in the reimbursement for the hospital bed  |
|   | Hospital bed rails are included in the reimbursement for hospital beds with bed rails  |
|   | Hospital bed rails and mattresses are included in the reimbursement for hospital beds with bed rails and mattresses in their description   |
| Intrapulmonary percussive ventilation (IPV) systems   | Intrapulmonary percussive ventilation systems are not covered in the home, assisted living, group home, or custodial care setting  |
| Lower limb prosthesis   | A below-knee suction socket or suction suspension for an above-knee or knee disarticulation socket is not separately reimbursed with a knee suspension locking mechanism               |
|   | A custom fabricated socket insert is not eligible for reimbursement when reported with a replacement prosthesis or addition  |
|   | Lower extremity diagnostic test sockets are included in reimbursement for immediate prosthesis   |
|   | A maximum of two test (diagnostic) sockets for an individual prosthesis is considered for reimbursement.   |
|   | Special features for lower limb prosthesis (such as multiaxial ankle/foot, flexfoot system, high activity knee) is considered for reimbursement based on the member's functional level |
| Special features/additions added at the time of provision of the preparatory prosthesis are not separately reimbursed |  |

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage**

| <b>Category</b>                                | <b>Coding Edit</b>   |
|--|--|
|  | Replacement prosthesis components are not reimbursable when reported with a prosthesis   |
| Manual and power wheelchair accessories        | Manual wheelchair accessories are appropriately reported when used with manual wheelchairs   |
|  | Power wheelchair accessories are appropriately reported when used with power wheelchairs   |
| Modifiers                                      | Prosthetics and orthotics that can be reported bilaterally require an RT (right) and/or LT (left) modifier   |
|  | Lower limb prostheses require a valid and appropriate functional modifier (K0-K4)  |
|  | A prosthesis is reimbursable when there is expectation that the amputee reaches or maintains a defined functional state within a reasonable time frame and when reported with the appropriate modifier   |
|  | Capped rental modifiers are restricted to usage with items listed as capped rental equipment by the Centers for Medicare and Medicaid Services (CMS)   |
|  | Items requiring an order prior to delivery (pressure reducing surfaces, power operated vehicles, seat lift mechanisms, or TENS units) are reimbursable when a written order is on file prior to delivery. In this case, report the code with modifier EY |
|  | For DMEPOS providers, adhesive tape requires an appropriate modifier (AU, AV, AW or AX.). Adhesive tape is not reimbursable in an office setting   |
| Nebulizers                                     | Disposable large volume nebulizers are non-covered items   |
|  | Controlled inhalation medication delivery system is eligible for reimbursement when reported with the appropriate medication   |
|  | A pharmacy supply fee is reimbursable when reported with the appropriate medications   |
|  | A 90-day dispensing fee is reimbursable once per 90 days   |
|  | A 30-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 90-day pharmacy dispensing fee   |
|  | A 90-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 30-day pharmacy dispensing fee   |
|  | A 30-day pharmacy dispensing fee for inhalation medication(s) is reimbursable once per month   |
| Non-contact normothermic wound warming devices | The non-contact wound warming device and accessories are not eligible for reimbursement as they are not considered safe nor effective  |
| Osteogenesis stimulators                       | Only one type of osteogenesis (bone) stimulator is reimbursable for covered fractures  |
| Ostomy supplies                                | Components of a more complete kit are included in the reimbursement for the kit  |

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage**

| <b>Category</b>                    | <b>Coding Edit</b>   |
|------------------------------------|--|
|                                    | Options and accessories that are part of a more complete ostomy product are included in the reimbursement for the ostomy appliance   |
| Oxygen and oxygen equipment        | Only one oxygen stationary system rental is reimbursable per month for those who qualify for coverage  |
|                                    | Portable oxygen rental is reimbursable once per month  |
|                                    | Frequently serviced items, such as oxygen systems, are reimbursable as a rental only   |
|                                    | Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement  |
|                                    | Oxygen contents reimbursement is included in the reimbursement for monthly rental of a stationary oxygen system  |
|                                    | Oxygen modifiers QE, QF and QG are recognized only when submitted with stationary oxygen rentals   |
| Parenteral nutrition               | Oxygen is included in monthly oxygen system rental   |
|                                    | Parental nutrition administration pumps are reimbursable once per month  |
|                                    | Homemix nutrient and component solutions are included in the reimbursement for the complete premix solution  |
|                                    | Parenteral nutrients solution is reimbursable at one unit per day  |
|                                    | One supply kit and one administration kit are reimbursable for each day that parenteral nutrition is administered  |
| Patient lifts                      | Use of an IV pole and parenteral nutrition pump in an outpatient setting is included in the reimbursement for the underlying nutrition service   |
|                                    | An electric patient lift with seat and a multi-positional patient support system with integrated lift are non-covered items  |
|                                    | Patient lifts for the toilet and patient lifts that are free moving or fixed are non-covered items   |
| Pneumatic compression devices      | A sling is included in the reimbursement for a patient lift  |
|                                    | A segmental pneumatic appliance is eligible for reimbursement when reported with a segmental pneumatic compressor  |
| Pressure reducing support surfaces | A non-segmental pneumatic compression appliance or segmental gradient pressure pneumatic appliance is eligible for reimbursement when reported with a non-segmental pneumatic compressor |
|                                    | Alternating pressure pad and pressure pad alternating pump replacement are included in the reimbursement for an alternating pressure pad with pump                                       |
| Prosthetic repair and replacement  | Labor is included in the reimbursement for the replacement prosthesis and components   |
|                                    | Labor for prosthetic repair is included in the reimbursement for the prosthesis when it is reported within 90 days of a prosthesis   |

| <b>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage</b> |  |
|--|--|
| <b>Category</b>  | <b>Coding Edit</b>   |
| Rentals  | Rental durable medical equipment (DME) is considered for reimbursement once per month  |
|  | Capped rental equipment is reimbursable for a total of 13 months   |
|  | Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months     |
| Repair   | Repair of DME is included in the initial provision of DME  |
| Transcutaneous electrical nerver stimulations (TENS)   | The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee |
| Urological Supplies  | A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device   |
|  | Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period  |
|  | Sterile intermittent catheters are reimbursable up to 600 times within 90 days   |
| Walkers  | Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement  |
| Wheelchair options and accessories   | Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option   |

\*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record

The following claims coding edits apply to Health Net claims for the Medicare Advantage (MA) line of business:

| <b>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</b>                        |  |
|---|--|
| <b>Category</b>   | <b>Coding Edit</b>   |
| Blood glucose monitoring  | Only one home blood glucose monitor is reimbursable per 12-month period of time  |
|   | A laser skin piercing device or replacement cartridge is reimbursed at the rate for the spring powered lancet and/or lancet replacements   |
|   | Urine test reagent strips, alcohol, peroxide, Betadine, and pHisoHex are not separately reimbursed with glucose monitors and supplies  |
| Diabetic shoes  | Only one pair of therapeutic shoes for members with diabetes is reimbursable per calendar year   |
|   | Therapeutic shoe inserts or modifications for members with diabetes are reimbursable up to six units per calendar year   |
|   | Diabetic shoe inserts or modifications reported with non-diabetic footwear are not eligible for reimbursement  |
| Enteral nutrition   | Nasogastric tubes are reimbursable once a month  |
| Eye prosthesis  | An eye prosthesis is eligible for replacement once the useful lifetime of the prosthesis is reached (typically five years)   |
| Lower limb prosthesis   | Two test sockets are reimbursable per individual prosthesis  |
| Nebulizers  | Corrugated tubing for use with a large volume nebulizer is reimbursable once per two months  |
|   | An immersion heater for a nebulizer or durable bottle type nebulizer is reimbursable once per three years  |
|   | A non-disposable administration set used with a small volume nebulizer reimbursable once every six months  |
|   | The non-disposable administration set is reimbursable once every three months if used with a controlled dose inhalation delivery system  |
|   | Atropine, administered by nebulizer, is reimbursable up to 558 units every 3 months  |
|   | Bitolterol, administered by nebulizer, is reimbursable up to 1302 units every 3 months   |
|   | Glycopyrrolate, administered by nebulizer, is reimbursable up to 225 units every 3 months  |
|   | Isoetharine HCL, administered by nebulizer, is reimbursable up to 2790 units every 3 months  |
|   | Metaproteranol sulfate, administered by nebulizer, is reimbursable up to 740 units every 3 months  |
|   | Terbutaline sulfate, administered by nebulizer, is reimbursable up to 558 units every 3 months   |
| Isoproterenol HCL, administered by nebulizer, is reimbursable up to 1350 units every 3 months |  |
| Orthopedic footwear   | Orthopedic footwear and the associated inserts or modifications are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier* |
|   | Custom-molded prosthetic shoes are not reimbursable when reported with partial foot prosthesis or other lower extremity prosthesis   |
| Oxygen and oxygen   | Oximeters and replacement probes are not covered because they do not meet the definition of DME  |

| <b>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</b> |   |
|--|---|
| <b>Category</b>  | <b>Coding Edit</b>  |
| equipment  | Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement<br>Oxygen is included in monthly oxygen system rental   |
| Pneumatic compression devices  | Only one type of pneumatic compressor (lymphedema pump) is eligible for reimbursement in the same month   |
| Rental   | Capped rental equipment is reimbursable for a total of 13 months<br>Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months  |
| Replacement  | Durable medical equipment is eligible for replacement after its useful lifetime has been reached (typically a period of 5 years).   |
| Transcutaneous electrical nerve stimulations (TENS)                    | The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee  |
| Urological supplies  | Urinary catheter insertion trays are considered for reimbursement at the frequency of two per calendar month. An additional two foley catheters are considered for reimbursement in the same month<br>Bedside urinary drainage bags are eligible for reimbursement at the frequency of two per month<br>Adhesive tape used with ostomy or urological supplies is eligible for reimbursement up to 40 units per month<br>A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device<br>Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period<br>Sterile intermittent catheters are reimbursable up to 600 times within 90 days |
| Walkers  | When an enclosed walker with rear seat is provided, it is reimbursed at the rate of a standard walker<br>Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement  |
| Wheelchair options and accessories                                     | Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option  |

\*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record.

All claims submissions remain subject to Health Net's prior authorization requirements.



Health Net does not require documentation at the time of claim submission. In the event the claim is audited, documentation may be required.

**Supporting Sources:**

- DME MAC
- HCPCS Level II
- Medicare National Coverage Determinations Manual (NCD)





## Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Gestation in Weeks: \_\_\_\_\_

As you are having a baby, we would like to know how you are feeling. Please mark “X” in the box next to the answer which comes closest to how you have felt in the **past 7 days**—not just how you feel today.

### ***In the past 7 days:***

- |  |  |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <p>0 <input type="checkbox"/> As much as I always could</p> <p>1 <input type="checkbox"/> Not quite so much now</p> <p>2 <input type="checkbox"/> Definitely not so much now</p> <p>3 <input type="checkbox"/> Not at all</p> <p>2. I have looked forward with enjoyment to things</p> <p>0 <input type="checkbox"/> As much as I ever did</p> <p>1 <input type="checkbox"/> Rather less than I used to</p> <p>2 <input type="checkbox"/> Definitely less than I used to</p> <p>3 <input type="checkbox"/> Hardly at all</p> <p>3. I have blamed myself unnecessarily when things went wrong</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, some of the time</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, never</p> <p>4. I have been anxious or worried for no good reason</p> <p>0 <input type="checkbox"/> No, not at all</p> <p>1 <input type="checkbox"/> Hardly ever</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>3 <input type="checkbox"/> Yes, very often</p> <p>5. I have felt scared or panicky for no very good reason</p> <p>3 <input type="checkbox"/> Yes, quite a lot</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>1 <input type="checkbox"/> No, not much</p> <p>0 <input type="checkbox"/> No, not at all</p> | <p>6. Things have been getting on top of me</p> <p>3 <input type="checkbox"/> Yes, most of the time I haven't been able to cope</p> <p>2 <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual</p> <p>1 <input type="checkbox"/> No, most of the time I have coped quite well</p> <p>0 <input type="checkbox"/> No, I have been coping as well as ever</p> <p>7. I have been so unhappy that I have had difficulty sleeping</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, not at all</p> <p>8. I have felt sad or miserable</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, quite often</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, not at all</p> <p>9. I have been so unhappy that I have been crying</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, quite often</p> <p>1 <input type="checkbox"/> Only occasionally</p> <p>0 <input type="checkbox"/> No, never</p> <p>10. The thought of harming myself has occurred to me</p> <p>3 <input type="checkbox"/> Yes, quite often</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>1 <input type="checkbox"/> Hardly ever</p> <p>0 <input type="checkbox"/> Never</p> |
|--|--|

Total Score

*Talk about your answers to the above questions with your health care provider.*

*Translations for care-provider use available on PSBC website: [perinatalservicesbc.ca](http://perinatalservicesbc.ca).*

The Royal College of Psychiatrists 1987. From Cox, JL, Holden, JM, Sagovsky, R (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*. 150, 782–786. Reprinted with permission.



# Provider Reporting

## Data File Record Layouts

### COMMERICAL (ACE)

File Name: ELIGIBILITY

Report Number: ACE\_RPT\_BRM\_42

All records in this file are 512 bytes long. There are four record types: Header, Detail, COB, and the Trailer record. Data expressed in the "X" format is left justified and blank filled, data expressed in the "9" format is right-justified and zero filled.

#### Header Record

| Field Name          | Position | Format | Description                                      |
|---------------------|----------|--------|--|
| Record Type         | 001-001  | X(1)   | "1" = Header record                              |
| Title               | 002-009  | X(8)   | "ELIG HDR"                                       |
| Info Effective Date | 010-017  | X(8)   | CCYYMMDD, effective date                         |
| Provider Type       | 018-018  | X(1)   | "M" = Medical Provider - "H" = Hospital Provider |
| Provider ID         | 019-022  | X(4)   | PPG, or Hospital Number                          |
| Provider Name       | 023-055  | X(33)  | PPG, or Hospital Name                            |
| Address             | 056-080  | X(25)  | PPG, or Hospital Address                         |
| City                | 081-097  | X(17)  | PPG, or Hospital City                            |
| State               | 098-099  | X(2)   | PPG, or Hospital State                           |
| Zip Code            | 100-108  | X(9)   | PPG, or Hospital Zip Code                        |
| Filler              | 109-512  | X(404) | Blank Spaces (Not Used)                          |

#### Detail Record

| Field Name              | Position | Format | Description   |
|-------------------------|----------|--------|---|
| Record Type             | 001-001  | X(1)   | "2" = Detail Record   |
| Member's Last Name      | 002-018  | X(17)  | Member's Last Name  |
| Member's First Name     | 019-028  | X(10)  | Member's First Name   |
| Member's Middle Initial | 029-029  | X(1)   | Member's Middle Initial   |
| Person ID               | 030-038  | X(9)   | Person ID   |
| Group ID                | 039-046  | X(8)   | Health Net Employer / Individual Group Number   |
| Member Code             | 047-049  | X(3)   | A code that describes the member's sex and a member's relationship to the subscriber    |
| Insight Indicator       | 050-050  | X(1)   | Y/N Member has Mental Health Benefits   |
| Plan Code               | 051-054  | X(4)   | Medical Plan of the employer / individual group the member belongs to                   |
| Office Visit Co-pay     | 055-057  | X(3)   | Office Visit Co-pay   |
| DME Benefit             | 058-060  | X(3)   | Durable Medical Equipment benefit Co-pay  |
| ER Benefit              | 061-063  | X(3)   | Emergency Room Co-pay   |
| COB ID                  | 064-071  | X(8)   | Coordination of Benefits ID   |
| Birth date              | 072-079  | X(8)   | CCYYMMDD, Member's birth date   |
| Satellite Provider ID   | 080-083  | X(4)   | Used only for consolidated files. Displays site where member is enrolled                |
| Physician ID            | 084-089  | X(6)   | If physician level report, Health Net assigned PCP number, otherwise will be PPG number |
| Provider Effective Date | 090-097  | X(8)   | CCYYMMDD, the date member is effective with this medical group                          |

|                       |         |       |   |
|-----------------------|---------|-------|---|
| Cancel Effective Date | 098-105 | X(8)  | CCYMMDD, the date member cancelled with this medical group  |
| Product Code          | 106-109 | X(4)  | HMO="HMO Medical", SNN="Silver Network", etc.   |
| Fund Type             | 110-110 | X(1)  | Claims Funding Type – R=Regular, S=Self, F=Flex   |
| Rx Indicator          | 111-111 | X(1)  | Pharmacy Benefit Indicator - Y/N  |
| PR_TY                 | 112-112 | X(1)  | PR_TY   |
| Member Address_50     | 113-162 | X(50) | Member's full Address   |
| Member City           | 163-179 | X(17) | Member's City   |
| Member State          | 180-181 | X(2)  | Member's State  |
| Member Zip Code       | 182-190 | X(9)  | Member's Zip Code   |
| Member Phone Number   | 191-200 | X(10) | Member's Home Phone Number  |
| Member Reference ID   | 201-209 | X(9)  | Member Reference ID   |
| Spoken Language       | 210-212 | X(3)  | Member Preferred Spoken Language (ISO code)   |
| Written Language      | 213-215 | X(3)  | Member Preferred Written Language (ISO code)  |
| Race                  | 216-218 | X(3)  | Member Race   |
| Ethnicity             | 219-221 | X(3)  | Member ethnicity  |
| APTC flag             | 222-222 | X(1)  | APTC flag   |
| DLQ flag              | 223-223 | X(1)  | Delinquency flag  |
| DIQ month indicator   | 224-224 | X(1)  | Delinquency month indicator   |
| DIQ start date        | 225-232 | X(8)  | Delinquency start date  |
| DIQ end date          | 233-240 | X(8)  | Delinquency end date  |
| Tribal flag           | 241-241 | X(1)  | Tribal flag   |
| Aid category          | 242-244 | X(3)  | Aid category  |
| Aid code              | 245-246 | X(2)  | Aid code  |
| Project code          | 247-249 | X(3)  | Project code  |
| CIN number            | 250-258 | X(9)  | (Medi-Cal) Client Identification Number   |
| Medi-Cal case id      | 259-272 | X(14) | Medi-Cal case id  |
| Medicare stat A       | 273-273 | X(1)  | Medicare stat A   |
| Medicare Stat B       | 274-274 | X(1)  | Medicare Stat B   |
| Medicare stat D       | 275-275 | X(1)  | Medicare stat D   |
| SPD/Dual flag         | 276-276 | X(1)  | SPD/Dual flag   |
| CCS Flag              | 277-278 | X(2)  | CCS Flag  |
| PCP Name              | 279-308 | X(30) | Member's PCP Name   |
| Redetermination date  | 309-316 | X(8)  | Annual Redetermination date   |
| Med provider id       | 317-321 | X(5)  | Member's medical provider id  |
| Full payment date     | 322-329 | X(8)  | Full payment date   |
| PCP Site id           | 330-337 | X(8)  | PCP's site id   |
| HCP Code              | 338-339 | X(2)  | HCP Code  |
| RC Indicator          | 340-340 | X(1)  | Regional Center Indicator Value "Y" or "N"  |
| RC name               | 341-390 | X(50) | Regional Center name  |
| Alternate Format      | 391-393 | X(03) | Alternate Format  |
| Member Suffix         | 394-396 | X(03) | Member Suffix   |
| Assignment Type       | 397-398 | X(02) | C – Choice, PT – Provider Transfer,<br>DF – Default Family Choice,<br>DP – Default Prior Choice,<br>D – Default Value         |
| Filler                | 399-400 | X(02) | Blank Spaces (Not Used)   |
| OHC Policy ID         | 401-415 | X(15) | Policy ID for Other Health Coverage   |
| Filler                | 416-416 | X(1)  | Blank Space   |
| OHC Effective Date    | 417-424 | X(8)  | Effective Date of Other Health Coverage   |
| Filler                | 425-425 | X(1)  | Blank Space   |
| OHC Expiration Date   | 426-433 | X(8)  | Expiration Date of Other Health Coverage  |
| Filler                | 434-434 | X(1)  | Blank Space   |
| OHC Code Curr Month   | 435-435 | X(1)  | Other Health Coverage Code from 834 file<br>A - Pay and chase (applies to any carrier)<br>C - Military benefits comprehensive |

|                         |         |       |  |
|-------------------------|---------|-------|--|
|                         |         |       | E - Vision plans   |
|                         |         |       | F - Medicare Part C health plan  |
|                         |         |       | G - Medical parolee  |
|                         |         |       | H - Multiple plans comprehensive   |
|                         |         |       | I - Institutionalized  |
|                         |         |       | K - Kaiser   |
|                         |         |       | N - No OHC   |
|                         |         |       | P - Preferred Provider Organization/Prepaid Health Plan/Health Maintenance Organization/Exclusive Provider Organization or not otherwise specified |
|                         |         |       | V - Any carrier other than the above (includes multiple coverage)  |
|                         |         |       | W - Multiple plans non-comprehensive   |
| Filler                  | 436-441 | X(6)  | OHC Code in effect for previous month  |
| Original Effective Date | 442-449 | X(8)  | Original effective date with the health plan (reserved for future use)   |
| Filler                  | 450-450 | X(1)  | Blank Space  |
| Department code         | 451-456 | X(6)  | Department code  |
| Filler                  | 457-512 | X(56) | Blank Space (not used)   |

### COB Record

| Field Name          | Position | Format | Description             |
|---------------------|----------|--------|-------------------------|
| Record Type         | 001-001  | X(1)   | "3" = COB Record        |
| COB Carrier id      | 002-009  | X(8)   | Table COB carrier id    |
| COB Carrier Name    | 010-039  | X(30)  | COB Carrier Name        |
| OHC_Address_1       | 040-064  | X(25)  | OHC_Address_1           |
| OHC_Address_2       | 065-089  | X(25)  | OHC_Address_2           |
| OHC_City            | 090-106  | X(17)  | OHC_City                |
| OHC_State           | 107-108  | X(02)  | OHC_State               |
| OHC_ZIP_Code        | 109-119  | X(11)  | OHC_ZIP Code            |
| OHC_Carrier Phone 1 | 120-134  | X(15)  | OHC_Carrier_Phone 1     |
| OHC_Carrier Phone 2 | 135-149  | X(15)  | OHC_Carrier_Phone 2     |
| OHC_Carrier Phone 3 | 150-164  | X(15)  | OHC_Carrier_Phone 3     |
| OHC_Remark 1        | 165-214  | X(50)  | OHC_Remark 1            |
| OHC_Remark 2        | 215-264  | X(50)  | OHC_Remark 2            |
| Filler              | 265-512  | X(248) | Blank Spaces (Not Used) |

### Trailer Record

| Field Name             | Position | Format | Description  |
|------------------------|----------|--------|--|
| Record Type            | 001-001  | X(1)   | "4" = Trailer Record                                 |
| Title                  | 002-009  | X(8)   | "ELIG SUM"   |
| Total Members EOM      | 010-017  | 9(8)   | Total Members as of month end                        |
| Total Members in Month | 018-025  | 9(8)   | Total members eligible at least one day of the month |
| Total member SPC       | 026-033  | X(8)   | Member SPC   |
| Total member SP1       | 034-041  | X(8)   | Member SP1   |
| Filler                 | 042-512  | X(471) | Blank Spaces (Not Used)                              |





## **HEPATITIS B VACCINATION DECLINATION**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

---

Signature of Employee

---

Date



## ICD-10-CM Codes for Abortion-Related Services

This list contains principal diagnosis codes for abortion and abortion-related services. If a code from this list is used as the principal diagnosis code, the services related to abortion will be processed by our claims processing systems at zero cost share to the member in accordance with Senate Bill 245 (the Abortion Accessibility Act). **Note: This list may not be all-inclusive and is subject to change.**

| ICD-10 Codes | Descriptions  |
|--------------|---|
| 000.00       | Abdominal pregnancy without intrauterine pregnancy.                           |
| 000.01       | Abdominal pregnancy with intrauterine pregnancy.                              |
| 000.101      | Right tubal pregnancy without intrauterine pregnancy.                         |
| 000.102      | Left tubal pregnancy without intrauterine pregnancy.                          |
| 000.109      | Unspecified tubal pregnancy without intrauterine pregnancy.                   |
| 000.111      | Right tubal pregnancy with intrauterine pregnancy.                            |
| 000.112      | Left tubal pregnancy with intrauterine pregnancy.                             |
| 000.119      | Unspecified tubal pregnancy with intrauterine pregnancy.                      |
| 000.201      | Right ovarian pregnancy without intrauterine pregnancy.                       |
| 000.202      | Left ovarian pregnancy without intrauterine pregnancy.                        |
| 000.209      | Unspecified ovarian pregnancy without intrauterine pregnancy.                 |
| 000.211      | Right ovarian pregnancy with intrauterine pregnancy.                          |
| 000.212      | Left ovarian pregnancy with intrauterine pregnancy.                           |
| 000.219      | Unspecified ovarian pregnancy with intrauterine pregnancy.                    |
| 000.80       | Other ectopic pregnancy without intrauterine pregnancy.                       |
| 000.81       | Other ectopic pregnancy with intrauterine pregnancy.                          |
| 000.90       | Unspecified ectopic pregnancy without intrauterine pregnancy.                 |
| 000.91       | Unspecified ectopic pregnancy with intrauterine pregnancy.                    |
| 001.1        | Incomplete and partial hydatidiform mole.                                     |
| 001.9        | Hydatidiform mole, unspecified.   |
| 002.1        | Missed abortion.  |
| 003.0        | Genital tract and pelvic infection following incomplete spontaneous abortion. |
| 003.1        | Delayed or excessive hemorrhage following incomplete spontaneous abortion.    |
| 003.2        | Embolism following incomplete spontaneous abortion.                           |
| 003.30       | Unspecified complication following incomplete spontaneous abortion.           |
| 003.32       | Renal failure following incomplete spontaneous abortion.                      |
| 003.33       | Metabolic disorder following incomplete spontaneous abortion.                 |

| <b>ICD-10 Codes</b> | <b>Descriptions</b>  |
|---------------------|--|
| <b>O03.34</b>       | Damage to pelvic organs following incomplete spontaneous abortion.                         |
| <b>O03.35</b>       | Other venous complications following incomplete spontaneous abortion.                      |
| <b>O03.36</b>       | Cardiac arrest following incomplete spontaneous abortion.                                  |
| <b>O03.37</b>       | Sepsis following incomplete spontaneous abortion.  |
| <b>O03.38</b>       | Urinary tract infection following incomplete spontaneous abortion.                         |
| <b>O03.39</b>       | Incomplete spontaneous abortion with other complications.                                  |
| <b>O03.4</b>        | Incomplete spontaneous abortion without complication.                                      |
| <b>O03.5</b>        | Genital tract and pelvic infection following complete or unspecified spontaneous abortion. |
| <b>O03.6</b>        | Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion.    |
| <b>O03.7</b>        | Embolism following complete or unspecified spontaneous abortion.                           |
| <b>O03.80</b>       | Unspecified complication following complete or unspecified spontaneous abortion.           |
| <b>O03.81</b>       | Shock following complete or unspecified spontaneous abortion.                              |
| <b>O03.82</b>       | Renal failure following complete or unspecified spontaneous abortion.                      |
| <b>O03.83</b>       | Metabolic disorder following complete or unspecified spontaneous abortion.                 |
| <b>O03.84</b>       | Damage to pelvic organs following complete or unspecified spontaneous abortion.            |
| <b>O03.85</b>       | Other venous complications following complete or unspecified spontaneous abortion.         |
| <b>O03.86</b>       | Cardiac arrest following complete or unspecified spontaneous abortion.                     |
| <b>O03.87</b>       | Sepsis following complete or unspecified spontaneous abortion.                             |
| <b>O03.88</b>       | Urinary tract infection following complete or unspecified spontaneous abortion.            |
| <b>O03.89</b>       | Complete or unspecified spontaneous abortion with other complications.                     |
| <b>O03.9</b>        | Complete or unspecified spontaneous abortion without complication.                         |
| <b>O04.5</b>        | Genital tract and pelvic infection following (induced) termination of pregnancy.           |
| <b>O04.6</b>        | Delayed or excessive hemorrhage following (induced) termination of pregnancy.              |
| <b>O04.7</b>        | Embolism following (induced) termination of pregnancy.                                     |
| <b>O04.80</b>       | (Induced) termination of pregnancy with unspecified complications.                         |
| <b>O04.81</b>       | Shock following (induced) termination of pregnancy.  |
| <b>O04.82</b>       | Renal failure following (induced) termination of pregnancy.                                |
| <b>O04.83</b>       | Metabolic disorder following (induced) termination of pregnancy.                           |
| <b>O04.84</b>       | Damage to pelvic organs following (induced) termination of pregnancy.                      |
| <b>O04.85</b>       | Other venous complications following (induced) termination of pregnancy.                   |
| <b>O04.86</b>       | Cardiac arrest following (induced) termination of pregnancy.                               |
| <b>O04.87</b>       | Sepsis following (induced) termination of pregnancy.                                       |
| <b>O04.88</b>       | Urinary tract infection following (induced) termination of pregnancy.                      |

| <b>ICD-10 Codes</b> | <b>Descriptions</b>   |
|---------------------|---|
| <b>O04.89</b>       | (Induced) termination of pregnancy with other complications.                            |
| <b>O07.0</b>        | Genital tract and pelvic infection following failed attempted termination of pregnancy. |
| <b>O07.1</b>        | Delayed or excessive hemorrhage following failed attempted termination of pregnancy.    |
| <b>O07.2</b>        | Embolism following failed attempted termination of pregnancy.                           |
| <b>O07.30</b>       | Failed attempted termination of pregnancy with unspecified complications.               |
| <b>O07.31</b>       | Shock following failed attempted termination of pregnancy.                              |
| <b>O07.32</b>       | Renal failure following failed attempted termination of pregnancy.                      |
| <b>O07.33</b>       | Metabolic disorder following failed attempted termination of pregnancy.                 |
| <b>O07.34</b>       | Damage to pelvic organs following failed attempted termination of pregnancy.            |
| <b>O07.35</b>       | Other venous complications following failed attempted termination of pregnancy.         |
| <b>O07.36</b>       | Cardiac arrest following failed attempted termination of pregnancy.                     |
| <b>O07.37</b>       | Sepsis following failed attempted termination of pregnancy.                             |
| <b>O07.38</b>       | Urinary tract infection following failed attempted termination of pregnancy.            |
| <b>O07.39</b>       | Failed attempted termination of pregnancy with other complications.                     |
| <b>O07.4</b>        | Failed attempted termination of pregnancy without complication.                         |
| <b>O08.2</b>        | Embolism following ectopic and molar pregnancy.   |
| <b>O08.3</b>        | Shock following ectopic and molar pregnancy.  |
| <b>O08.4</b>        | Renal failure following ectopic and molar pregnancy.                                    |
| <b>O08.82</b>       | Sepsis following ectopic and molar pregnancy.   |
| <b>O08.83</b>       | Urinary tract infection following an ectopic and molar pregnancy.                       |
| <b>O08.89</b>       | Other complications following an ectopic and molar pregnancy.                           |
| <b>O20.0</b>        | Threatened abortion.  |
| <b>O20.8</b>        | Other hemorrhage in early pregnancy.  |
| <b>O20.9</b>        | Hemorrhage in early pregnancy, unspecified.   |
| <b>Q89.7</b>        | Multiple congenital malformations, not elsewhere classified.                            |
| <b>Z33.2</b>        | Encounter for elective termination of pregnancy.  |
| <b>Z64.0</b>        | Problems related to unwanted pregnancy.   |





**ELECT OPEN ACCESS**

**Member ID # [XXXXXXXXXXXX]**

**Medical Group and PCP**

OU7 Health Care Partners of Los Angeles  
1-818-773-4433  
4747 Buena Vista St.  
Burbank, CA 91505-7865  
Effective date with PPG: MM/DD/YYYY

Dr. Martin Short  
1-818-773-4433

In case of emergency call 911

| Deductibles | In-Network | Out-of-Network | Out of Pocket Max | In-Network | Out-of-Network |
|-------------|------------|----------------|-------------------|------------|----------------|
| One Member  | \$X,XXX    | \$X,XXX        | One Member        | \$X,XXX    | \$X,XXX        |
| Family      | \$X,XXX    | \$X,XXX        | Family            | \$X,XXX    | \$X,XXX        |

Member FIRST MI LASTNAME  
Subscriber FIRST M LASTNAME  
Effective Date 01/01/2020  
Group Name From ABS or PEGA  
Group # 234532  
Plan Xxxxxx

|               | Your Health Net Provider | Other Health Net participating providers |
|---------------|--------------------------|--|
| PCP visit     | \$XX                     | \$XX                                     |
| Minute Clinic | \$XX                     |  |
| Specialist    | \$XX                     | \$XX                                     |
| Urgent Care   | \$XX                     | \$XX                                     |
| ER            | \$XXX                    | \$XXX                                    |

**www.healthnet.com**

|   |                           |
|---|---------------------------|
| Member Services                         | 1-800-676-6976 (TTY: 711) |
| Mental Health Benefits and Appointments | 1-888-426-0030 (TTY: 711) |
| 24-hour Nurse Advice Line               | 1-800-893-5597 (TTY: 711) |
| 24/7 Video Doctor Appointment           | www.teladoc.com           |

**Provider Services** 1-800-641-7761  
**To report, or request approval for, inpatient admits, call:** 1-800-995-7890  
**Pharmacy Help Desk** 1-800-600-0180  
RxBIN #004336 RxPCN 'HNET' Processor Caremark

**California Medical & Mental Health Benefit Claims**  
Health Net Commercial Claims  
Payer ID 95567, PO Box 9040  
Farmington, MO 63640-9040

**Outside of California Medical & Mental Health Benefit Claims**  
Cigna Medical Claims  
Payer ID 62308, PO Box 188061  
Chattanooga, TN 37422-8061

Health Net of California, Inc. provides the health benefits under this plan

Benefits are not insured by Cigna or affiliates



AWAY FROM HOME CARE

**Your Health Net ID Card**

Attached is a new Health Net ID Card. If there is an error on this card, or you have any questions about your coverage, please call Health Net's Member Services and provide them with your Group and Subscriber ID number. You will find the Member Services phone number on the back of this card and your Group and Subscriber ID number on the face of this card.

Carry this ID Card with you at all times, and present it to your health care provider when getting the care you need.

See your plan documents for a description of your benefits.

**Your Primary Care Physician**

Your PCP oversees all your health care and provides referrals if specialty care is needed. Your health plan uses the Elect Open Access provider network. In order to be covered please make sure you use doctors, hospitals, etc. that are in the Elect Open Access provider network. If your situation is an emergency, call 911 or go to the nearest hospital or emergency care facility.

**Prior Authorization Requirements**

For a current listing of services subject to prior authorization before they are rendered, please refer to your Evidence of Coverage or Certificate of Insurance. You may also visit Health Net's website at www.healthnet.com or call the Customer Contact Center at 1-800-361-3366 (TTY: 711).

**Teladoc 24/7 Video Doctor Visits**

Your new telehealth service provider is Teladoc. Teladoc gives you 24/7 access to U.S. board-certified doctors. You can access them with ease – either through the web, your phone or through the Teladoc app. Get the care you need in minutes from the comfort of home or at work. Or, get care even while traveling!

You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, a treating specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through Teladoc will accrue toward your out-of-pocket maximum and deductible (if your plan has a deductible). By scheduling through Teladoc, you consent to receive services via telehealth through Teladoc. See your health plan coverage document for coverage information and for the definition of telehealth services. You have a right to access your medical records for services received through Teladoc. Unless you choose otherwise, any services provided through Teladoc shall be shared with your primary care provider.

**IF AN EMERGENCY ARISES**

If your situation is an emergency: Call 911 or go to the nearest Hospital or emergency care facility. If you are ill but unsure of the seriousness of your condition: You may call your Medical Group for assistance. In all cases, contact your Primary Care Physician/Medical Group as soon as possible to inform them about your condition.







PO Box 989883, West Sacramento, CA 95798-9883

ELECTRONIC SERVICE REQUESTED

90703

[MEMBERS NAME]

[MEMBERS MAILING ADDRESS]

[MEMBERS CITY STATE ZIP + 4]

**IFP Ambetter PPO network**

**Member ID#** [R/Uxxxxxxxxxx]

Effective date with PCP [MM/DD/YYYY]

**Primary Care Physician Information**

[PCP ID]  
[PCP NAME]  
[PCP Street Address]  
[PCP City, State Zip]  
[PCP Phone number]



**Member name** [FIRST MI LAST NAME]  
**Subscriber** [FIRST LAST NAME]  
**Effective date** [MM/DD/YYYY]  
**Plan** [XXX] Including Metallic Level and Actuarial Number

**Health Net of California, Inc.**

(Copays may apply after deductible)  
**PCP Visit** \$XX **Specialist Visit** \$XX **ER** \$XXX **Urgent Care** \$XX **Teladoc** \$XX

### **Your Health Net ID card**

Attached is your new Health Net member identification card. Please discard any old identification cards you may have from Health Net. If there is an error on this card, or you need to verify eligibility for benefits, please call us at 1-844-463-8188 (TTY: 711). Please see your Policy for full plan details.

### **Your primary care physician**

You have selected or have been assigned the primary care physician (PCP) listed on your card. To receive the highest level of coverage, please make sure you choose providers (hospitals, doctors, etc.) that are in our Ambetter PPO provider network. You can see your PCP first, or you can go to any provider in the Ambetter PPO provider network. You don't need a referral. If your situation is an emergency, call 911 or go to the nearest hospital or emergency care facility. Want to change your PCP? You can:

- Go to [www.myhealthnetca.com](http://www.myhealthnetca.com) to find a doctor in the Ambetter PPO provider network.
- Call 1-844-463-8188 (TTY: 711), Monday through Friday, 8:00 a.m. to 6:00 p.m

### **Teladoc 24/7 Video Doctor Visits**

Teladoc gives you 24/7 access to U.S. board-certified doctors. You can access them with ease - either through the web, your phone or through the Teladoc app. Get the care you need in minutes from the comfort of home or at work. Or, get care even while traveling!

2023 Ambetter HMO and PPO plans are offered by Health Net of California, Inc. Health Net of California, Inc. (Health Net) are subsidiaries of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, a treating specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through Teladoc Health (Teladoc) will accrue toward your out-of-pocket maximum and deductible (if your plan has a deductible). By scheduling through Teladoc, you consent to receive services via telehealth through Teladoc. See your health plan coverage document for coverage information and for the definition of telehealth services. You have a right to access your medical records for services received through Teladoc. Unless you choose otherwise, any services provided through Teladoc shall be shared with your primary care provider.

**[www.myhealthnetca.com](http://www.myhealthnetca.com)**  
**Customer Contact Center**  
**Mental Health Benefits**  
**24-hour Nurse Advice**  
**Virtual Doctor Visits**

1-844-463-8188  
1-800-977-7534  
1-800-893-5597  
[www.Teladoc.com](http://www.Teladoc.com)

### **Prior Authorization**

You are responsible for obtaining prior authorization before certain services. Prior Authorization doesn't constitute eligibility for benefits and coverage, which are subject to eligibility rules and benefit limitations under the plan.

For prior authorization, call 1-800-977-7282







Member FIRST MI LASTNAME  
 Subscriber FIRST M LASTNAME  
 Effective Date 01/01/2020  
 Group Name From ABS or PEGA  
 Group # 234532  
 Plan Xxxxxx

PCP visit \$XX  
 Specialist \$XX  
 Urgent Care \$XX  
 ER \$XX

**PPO**  
**Member ID # [XXXXXXXXXXXX]**  
**Benefits & Eligibility:**  
**1-800-676-6976 (TTY: 711)**

When traveling outside of California, call 1-800-676-6976 or visit [www.healthnet.com](http://www.healthnet.com) to locate a Cigna PPO participating provider. For prior authorization services, call 1-800-977-7282. Authorization is not a guarantee of payment or coverage; member must be eligible at the time of service. In case of emergency call 911.

| Deductibles | In-Network | Out-of-Network | Out of Pocket Max | In-Network | Out-of-Network |
|-------------|------------|----------------|-------------------|------------|----------------|
| One Member  | \$X,XXX    | \$X,XXX        | One Member        | \$X,XXX    | \$X,XXX        |
| Family      | \$X,XXX    | \$X,XXX        | Family            | \$XX,XXX   | \$XX,XXX       |

[www.healthnet.com](http://www.healthnet.com)

Mental Health Benefits and Appointments 1-800-797-7016 (TTY: 711)  
 24-hour Nurse Advice 1-800-893-5597 (TTY: 711)  
 24/7 Video Doctor Appointment [www.teladoc.com](http://www.teladoc.com)

**Provider Services** 1-800-641-7761  
**To report, or request approval for, inpatient admits, call:** 1-800-995-7890  
**Pharmacy Help Desk** 1-800-600-0180  
 RxBIN #004336 RxPCN 'HNET' Processor Caremark

**California Medical & Mental Health Benefit Claims**  
 Health Net Commercial Claims  
 Payer ID 95567, PO Box 9040  
 Farmington, MO 63640-9040

**Outside of California Medical & Mental Health Benefit Claims**  
 Cigna Medical Claims  
 Payer ID 62308, PO Box 188061  
 Chattanooga, TN 37422-8061

Health Net of California, Inc. provides the health benefits under this plan

Benefits are not insured by Cigna or affiliates



Shared Administration PPO  
 Cigna is for in-network service outside of CA



Access may vary  
 AWAY FROM HOME CARE

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Member FIRST MI LASTNAME  
 Subscriber FIRST M LASTNAME  
 Effective Date 01/01/2020  
 Group Name From ABS or PEGA  
 Group # 234532  
 Plan Xxxxxx

PCP visit \$XX/\$XX/\$XX  
 Specialist \$XX/\$XX/\$XX  
 MinuteClinic \$XX/\$XX/\$XX  
 Urgent Care \$XX/\$XX/\$XX  
 ER \$XX/\$XX/\$XX

| Deductibles | Tier 1  | Tier 2  |
|-------------|---------|---------|
| One Member  | \$X,XXX | \$X,XXX |
| Family      | \$X,XXX | \$X,XXX |

**SELECT POS**  
 Member ID #[XXXXXXXXXXXX]

**Medical Group and PCP**  
 OU7 Health Care Partners of Los Angeles  
 1-818-773-4433  
 4747 Buena Vista St.  
 Burbank, CA 91505-7865  
 Effective date with PPG: MM/DD/YYYY

Dr. Martin Short  
 1-818-773-4433  
 In case of emergency call 911

| Out Of Pocket Max | Tier 1  | Tier 2  |
|-------------------|---------|---------|
| One Member        | \$X,XXX | \$X,XXX |
| Family            | \$X,XXX | \$X,XXX |

[www.healthnet.com](http://www.healthnet.com)

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Access may vary

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### Examples of IFP member eligibility status displayed on the secure provider portal

The image below shows examples of how member status displays when verifying eligibility for Individual and Family Plan (IFP) members on the secure provider portal. Status displays as “eligible” (thumbs up icon), “ineligible,” “delinquent,” or “suspended”:

|   |                 |              |              |   |
|---|-----------------|--------------|--------------|---|
| ELIGIBLE  | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | <i>Member is <b>eligible</b> for services performed on this date of service.</i>          |
|                  | 07/21/2016      | JOHN DOE     | 07/21/2016   |   |
| ELIGIBLE  | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | <i>Member is <b>not eligible</b> for services performed on this date of service.</i>      |
| <br>Ineligible   | 07/21/2016      | JOHN DOE     | 07/21/2016   |   |
| ELIGIBLE  | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | <i>Member's premium payment is in <b>delinquent status</b>. Claims will be processed.</i> |
| <br>Delinquent | 07/21/2017      | JOHN DOE     | 07/21/2017   |   |
| ELIGIBLE  | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | <i>Member's premium payment is past due status. <b>Claims may be denied</b>.</i>          |
| <br>Suspended  | 07/21/2016      | JOHN DOE     | 07/21/2016   |   |





## Provider Communications



# Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS



## INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

### Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: [CL\\_Team@iceforhealth.org](mailto:CL_Team@iceforhealth.org).

On behalf of the ICE Cultural and Linguistic Workgroup,

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Medical  
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Cigna, Health Equity  
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Clinical Nutritionist, Certified  
Gerontologist

Valencia Walker  
CTT+  
Cigna  
Language  
Assistance Services  
Manager

Lali (Eulalia) Witrago, MPH  
Health Net of California,  
Inc.  
Sr. Cultural and Linguistics  
Consultant

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**SECTION A: RESOURCES TO ASSIST COMMUNICATION  
WITH A DIVERSE PATIENT POPULATION BASE**



## A GUIDE TO INFORMATION IN SECTION A

### RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

**The following materials are available in this section:**

|  |  |
|--|--|
| <b>Working with Diverse Patients: Tips for Successful Patient Encounters</b>   | A tip sheet designed to help providers enhance their patient communication skills.   |
| <b>Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication</b>                                  | A tip sheet designed to help office staff enhance their patient communication skills.  |
| <b>Non-verbal Communication and Patient Care</b>   | An overview of the impact of nonverbal communication on patient-provider relations and communication.                              |
| <b>"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues</b>                          | A mnemonic to help you individualize care based on cultural/diversity aspects.   |
| <b>Tips for Identifying and Addressing Health Literacy Issues</b>  | A tip sheet to help understand and work with patients with Health literacy.  |
| <b>Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness</b>   | A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds. |
| <b>Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements</b>                          | Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.                        |
| <b>Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services</b> | A tip sheet to help providers communicate effectively with their patients.   |
| <b>Supporting Patients with 211 and 711 Community Services</b>   | A tip sheet to help providers utilize community services for patients with special needs.  |

## WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

**Styles of Speech:** *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

**Eye Contact:** *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

**Body Language:** *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

**Gently Guide Patient Conversation:** *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

## **PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION**

### **1. Build rapport with the patient.**

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

### **2. Make sure patients know what you do.**

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

### **3. Keep patients' expectations realistic.**

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

### **4. Work to build patients' trust in you.**

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

### **5. Determine if the patient needs an interpreter for the visit.**

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

### **6. Give patients the information they need.**

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

### **7. Make sure patients know what to do.**

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)



## NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

*Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.*

### Eye Contact



*Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.<sup>1</sup>*

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

### Touch and Use of Space

*A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.*

Talk the patient through each exam so that the need for the physical contact is

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<sup>1, 2</sup> Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.  
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication*. Hamburg: Gruner & Jahr.  
Hall, E.T. (1990). *Understanding Cultural Differences*. Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

### **Gestures**

*An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?<sup>1</sup>*

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

### **Body Posture and Presentation**

*Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.*

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

### **Use of Voice**

*Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.*

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

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<sup>1</sup> Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.  
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication*. Hamburg: Gruner & Jahr.  
Hall, E.T. (1990). *Understanding Cultural Differences*. Yarmouth, ME: Intercultural Press.

## “DIVERSE” A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

|          | Assessment  | Sample Questions   | Assessment Information/ Recommendations |
|----------|---|--|---|
| <b>D</b> | <b>Demographics-</b> Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.   | Where were you born?<br>Where was “home” before coming to the U.S.?<br>How long have you lived in the U.S.?<br>What is the patient’s age and sex?  |   |
| <b>I</b> | <b>Ideas-</b> ask the patient to explain his/her ideas or concepts of health and illness.   | What do you think keeps you healthy?<br>What do you think makes you sick?<br>What do you think is the cause of your illness?<br>Why do you think the problem started?  |   |
| <b>V</b> | <b>Views of health care treatments-</b> ask about treatment preference, use of home remedies, and treatment avoidance practices.  | Are there any health care procedures that might not be acceptable?<br>Do you use any traditional or home health remedies to improve your health?<br>What have you used before?<br>Have you used alternative healers? Which?<br>What kind of treatment do you think will work?  |   |
| <b>E</b> | <b>Expectations-</b> ask about what your patient expects from his/her doctor?   | What do you hope to achieve from today’s visit?<br>What do you hope to achieve from treatment?<br>Do you find it easier to talk with a male/female?<br>Someone younger/older?  |   |
| <b>R</b> | <b>Religion-</b> asks about your patient’s religious and spiritual traditions.  | Will religious or spiritual observances affect your ability to follow treatment? How?<br>Do you avoid any particular foods?<br>During the year, do you change your diet in celebration of religious and other holidays?  |   |
| <b>S</b> | <b>Speech-</b> identifies your patient’s language needs including health literacy levels. Avoid using a family member as an interpreter.  | What language do you prefer to speak?<br>Do you need an interpreter?<br>What language do you prefer to read?<br>Are you satisfied with how well you read?<br>Would you prefer printed or spoken instructions?  |   |
| <b>E</b> | <b>Environment –</b> identify patient’s home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient’s daily schedule, support system and level of independence. | Do you live alone?<br>How many other people live in your house?<br>Do you have transportation?<br>Who gives you emotional support?<br>Who helps you when you are ill or need help?<br>Do you have the ability to shop/cook for yourself?<br>What times of day do you usually eat?<br>What is your largest meal of the day? |   |

## TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

### LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards<sup>1</sup> as *"the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing."*

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

#### Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

#### Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

### TIPS FOR DEALING with LOW HEALTH LITERACY<sup>1</sup>

|   |   |
|---|---|
| <ul style="list-style-type: none"> <li>✓ Use simple words and avoid jargon.</li> <li>✓ Never use acronyms.</li> <li>✓ Avoid technical language (if possible).</li> <li>✓ Repeat important information – a patient's logic may be different from yours.</li> <li>✓ Ask patients to repeat back to you important information.</li> <li>✓ Ask open-ended questions.</li> <li>✓ Use medically trained interpreters familiar with cultural nuances.</li> </ul> | <ul style="list-style-type: none"> <li>✓ Give information in small chunks.</li> <li>✓ Articulate words.</li> <li>✓ “Read” written instructions out loud.</li> <li>✓ Speak slowly (don't shout).</li> <li>✓ Use body language to support what you are saying.</li> <li>✓ Draw pictures, use posters, models or physical demonstrations.</li> <li>✓ Use video and audio media as an alternative to written communications.</li> </ul> |
|---|---|

### ADDITIONAL RESOURCES

Use **Ask Me 3**<sup>2</sup>. Ask Me 3<sup>®</sup> is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3<sup>®</sup> and to view a video on how to use the questions, please visit <http://www.npsf.org/?page=askme3>. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).



### American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: <http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page>.

<sup>1</sup> Joint Committee on National Education Standards, 1995

<sup>2</sup> National Patient Safety Foundation, Ask Me 3<sup>®</sup>. <http://www.npsf.org/?page=askme3>

## INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.*



### INTERVIEW QUESTIONS

**Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.***

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

**Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.***

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

**Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?***

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

**Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.***

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.



## AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: [www.ada.gov/effective-comm.htm](http://www.ada.gov/effective-comm.htm).

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

### EFFECTIVE COMMUNICATION

#### Overview

**People who have vision, hearing, or speech disabilities (“communication disabilities”) use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.**

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities (“covered entities”) understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person’s normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity’s goods or services as well as with that person’s parent, spouse, or companion in appropriate circumstances.

### AUXILIARY AIDS AND SERVICES

The ADA uses the term “auxiliary aids and services” (“aids and services”) to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A “qualified” reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A “qualified” interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

| In addition, aids and services include a wide variety of technologies including:  |
|---|
| 1) Assistive listening systems and devices;   |
| 2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;   |
| 3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;  |
| 4) Videotext displays;  |
| 5) Screen reader software, magnification software, and optical readers;   |
| 6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;   |
| 7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers). |

## EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person’s normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.





For example:

*In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.*

*In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.*

**A person's method(s) of communication are also key.**

For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

**COMPANIONS**

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

**USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS**

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.



The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

#### WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

**Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.**

For more information about the ADA, please visit the website or call the toll-free number. [www.ADA.gov](http://www.ADA.gov)  
[ADA Information Line](#) 800-514-0301 (Voice) and 800-514-0383 (TTY)



## ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)  
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

| <b>Your patient may need assistance because ...</b>   | <b>These are some options we can provide for you.....</b>  |
|---|--|
| Am blind or have vision impairments that keep me from reading                                       | <ul style="list-style-type: none"> <li>- Large print materials</li> <li>- Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped <a href="https://www.loc.gov/nls/pdf/application.pdf">https://www.loc.gov/nls/pdf/application.pdf</a></li> <li>- Physician can complete form for Vision enabled telephone-- <a href="http://www.californiaphones.org/application">http://www.californiaphones.org/application</a></li> <li>-Check with health plans to see what they have available (audio recordings of printed materials, etc.)</li> </ul> |
| Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell | <ul style="list-style-type: none"> <li>- Amplifier/ Pocket Talker</li> <li>- Written materials</li> <li>- Qualified sign language interpreter</li> <li>- Qualified note taker</li> <li>- Telecommunications Relay Service (TRS) 7-1-1</li> <li>- Have physician dictate into voice-recognition software and patient can type answers back</li> </ul>   |
| Have difficulty speaking clearly and making myself understood                                       | <ul style="list-style-type: none"> <li>- Allow for extra time and attentive listening</li> <li>- Qualified note taker</li> <li>- Telecommunications Relay Services (TRS) 7-1-1</li> <li>- Communication board or paper and pencil</li> <li>- Have physician dictate into voice-recognition software and patient can type answers back</li> </ul>   |

\* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

### Resources

- The Gerontological Society of America  
[http://aging.arizona.edu/sites/aging/files/activity\\_1\\_reading\\_1.pdf](http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf)
- American Speech Language Hearing Association  
<http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/>
- Administration for Community Living DHHS  
[http://www.aoa.acl.gov/AoA\\_Programs/Tools\\_Resources/Older\\_Adults.aspx](http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx)
- The Look Closer, See Me Generational Diversity and Sensitivity training program  
[http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204\\_GDS\\_T\\_Reference%20Guide.pdf](http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDS_T_Reference%20Guide.pdf)
- U.S Department of Justice- ADA requirements for Effective Communication  
<https://www.ada.gov/effective-comm.htm>

# Language Services: The KEY to Patient Engagement

**Where do I start?**  
Check out the Q&A below to learn more...



**Why does my office need a language service plan?**



Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field<sup>1</sup>. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

**Where do I start?**



**Get Ready:**

- Gather your team
- Make a commitment
- Identify needs

**Get Set:** *identify resources*

**Go:** *pull it all together, implement, evaluate, plan for the future*

**What language service needs should I begin to identify?**



**Keep it simple and write down:**

- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

**Where can I find resources?**



- [Providing Language Services](#)
- [Incorporating Interpreter Services](#)
- [Self-assessment checklist](#)
- [Language Access Assessment and Planning Tool](#)

## Get Ready, Get Set, Go!

**Get ready!**

- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

**Get set!**

- Review resources and identify those most useful for your office

**Go!**

- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency



<sup>1</sup> Wirthlin Worldwide 2002 RWJF Survey





## **SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES**

**211 and 711** are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

### **211**

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies, and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

**For more information, look for your local 211.org.**

### **711**

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

**For more information, visit <http://ddtp.cpuc.ca.gov/homepage.aspx>**

## **Teletype Device**

### **Relay Operator**

### **Cell or Landline Phone**



**SECTION B: RESOURCES TO COMMUNICATE ACROSS  
LANGUAGE BARRIERS**

## A GUIDE TO INFORMATION IN SECTION B

### RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.



Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

|   |   |
|---|---|
| <b>Tips for Working with LEP Members</b>                                | Suggestions to help communicate with LEP patients.  |
| <b>Useful Tips for Communicating Across Language Barriers</b>           | Suggestions to help identify and document language needs.   |
| <b>Tips for Working with Interpreters</b>                               | Suggestions to maximize the effectiveness of an interpreter.  |
| <b>Tips for Locating Interpreter Services</b>                           | Information to know when locating interpreter services.   |
| <b>Common Sentences in Foreign Languages (Spanish &amp; Vietnamese)</b> | Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.    |
| <b>Common Signs in Foreign Languages (Spanish &amp; Vietnamese)</b>     | Simple signs that can be enlarged and posted in your facility.  |
| <b>Language Identification Flashcard</b>                                | Tool to identify patient languages.   |
| <b>Employee Language Pre-Screening Survey</b>                           | Pre-screening tool to identify employees that may be eligible for formal language proficiency testing |
| <b>Request for Proposal (RFP) Questions</b>                             | Sample screening questions to interview translation vendors   |

## TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

**California law** requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

### Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

### How to identify a LEP member over the phone



- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

### Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

*"I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?"*

**OR**

*"May I put you on hold? I am going to connect us with an interpreter." (If you are having a difficult time communicating with the member)*

### Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

*"In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"*

\*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

[http://www.hablamosjuntos.org/signage/symbols/default.using\\_symbols.asp#bpw](http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw)



## TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

### Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak..." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

### Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.  
(e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

### Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

### Tips to Overcome Language Barriers

|                           |  |
|---------------------------|--|
| <b>Use Simple Words</b>   | <ul style="list-style-type: none"> <li>• Avoid jargon and acronyms</li> <li>• Provide educational material in the languages your patients read</li> <li>• Limit/avoid technical language</li> </ul>  |
| <b>Speak Slowly</b>       | <ul style="list-style-type: none"> <li>• Do not shout, articulate words completely</li> <li>• Use pictures, demonstrations, video or audiotapes to increase understanding</li> <li>• Give information in small chunks and verify comprehension before going on.</li> </ul> |
| <b>Repeat Information</b> | <ul style="list-style-type: none"> <li>• Always confirm patient's understanding of the information - patient's logic may be different from yours</li> </ul>  |

## TIPS FOR WORKING WITH INTERPRETERS

### TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. \*
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." \*
- Speak in short sentences, expressing one idea at a time.\*
- Speak slower than your normal speed of talking, pausing after each phrase.\*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"\*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." \*
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.\*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." \*
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. \*
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.\*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. \*
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. \*\*

When the interpreter comes onto the line let the interpreter know the following: \*\*

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." \*\*

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. \*\*
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.\*\*

## ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. \*\*
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." \*\*
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. \*\*
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. \*\*
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. \*\*
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. \*\*





- Speak in: Standard English (avoid slang) \*\*
  - Layman's terms (avoid medical terminology and jargon)
  - Straightforward sentence structure
  - Complete sentences and ideas
- Ask one question at a time. \*\*
- Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. \*\*
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. \*\*
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. \*\*
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. \*\*
- Acknowledge the interpreter as a professional in communication. Respect his or her role. \*\*

\*\* "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.

\* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).



## TIPS FOR LOCATING INTERPRETER SERVICES

### Steps I need to take to locate interpreter services:

- 1) Identify the languages spoken by your patients, and
- 2) Identify the language services available to meet these needs

#### For example:

| Language spoken by my patients | Resources to help me communicate with patients |
|--------------------------------|--|
| Spanish                        | Certified bilingual staff                      |
| Armenian                       | Telephone interpreter or in person interpreter |

| Identify the language capability of your staff (See Employee Language Skills Self-Assessment)   |
|---|
| <ul style="list-style-type: none"> <li>• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. <b>IF you use a minor, document the reason a minor was used.</b></li> </ul> |

| <b>Identify services available do not require an individual with limited English proficiency to provide his/her own interpreter</b>   |
|---|
| <ul style="list-style-type: none"> <li>• <b>Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.</b></li> </ul>                               |
| <ul style="list-style-type: none"> <li>• <b>Identify community based qualified interpreter resources</b></li> </ul>   |
| <ul style="list-style-type: none"> <li>• <b>Create and provide to your staff policies and procedures to access interpreter services.</b></li> </ul>   |
| <ul style="list-style-type: none"> <li>• <b>Keep an updated list of specific telephone numbers and health plan contacts for language services.</b></li> </ul>   |
| <ul style="list-style-type: none"> <li>• <b>If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.</b></li> </ul>  |
| <ul style="list-style-type: none"> <li>• <b>711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.</b></li> </ul> |

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.



## LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.



# Interpreting Services Available

**English Translation:** Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

|   |   |
|---|---|
| <b>Arabic</b><br>العربية<br>أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجاناً.  | <b>Laotian</b><br>ພາສາລາວ<br>ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.                                 |
| <b>Armenian</b><br>Հայերեն<br>Ելեք, թե որ լեզվով եք խոսում: Թարգմանիչ կվանչեք: Թարգմանիչ ծառայությունները տրամադրվում են անվճար:                      | <b>Portuguese</b><br>Português<br>Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.               |
| <b>Bengali</b><br>বাংলা<br>আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বাভাষীকে ডাকা হবে। দ্বাভাষী আপনি নিখরচায় পাবেন।                                     | <b>Punjabi</b><br>ਪੰਜਾਬੀ<br>ਅਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।              |
| <b>Cambodian (Khmer)</b><br>ខ្មែរ (កម្ពុជា)<br>សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។                 | <b>Russian</b><br>Русский<br>Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.                   |
| <b>Chinese (Cantonese)</b><br>廣東話<br>請指認您的語言，以便為您提供免費的口譯服務。   | <b>Samoan</b><br>Fa'asamoa<br>Fa'asino lau gagana. Ole a vala'au se fa'amatala'upu. Ua saunia se fa'amatala'upu e aunoa ma se tau e te totogiina.           |
| <b>Chinese (Mandarin)</b><br>普通话<br>请指认您的语言，以便为您提供免费的口译服务。  | <b>Somali</b><br>Af-Soomaali<br>Farta ku fiiqluqadaada... Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.                     |
| <b>Farsi (Persian)</b><br>فارسی<br>زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد. | <b>Spanish</b><br>Español<br>Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.  |
| <b>Greek</b><br>Ελληνικά<br>Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.                                   | <b>Tagalog</b><br>Tagalog<br>Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.   |
| <b>Hindi</b><br>हिंदी<br>अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।      | <b>Thai</b><br>ไทย<br>ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาสามให้ท่าน การใช้สามไม่ต้องเสียค่าใช้จ่าย  |
| <b>Hmong</b><br>Hmoob<br>Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.        | <b>Tongan</b><br>Tongan Lea Faka-Tonga<br>Tuhu'i mai ho'o lea fakafonua. `E ui ha fakatonulea. `Oki ta'etotongi kia `a e fakatonulea.                       |
| <b>Japanese</b><br>日本語<br>あなたの話す言語を指してください。無料で通訳サービスを提供します。   | <b>Urdu</b><br>اردو<br>اپنی زبان پر اشارہ کریں۔ ایک ترجمان کو بلاجائے گا۔ ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا۔                               |
| <b>Korean</b><br>한국어<br>귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.   | <b>Vietnamese</b><br>Tiếng Việt<br>Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên. |

Provided courtesy of Industry Collaboration Effort and LanguageLine Solutions.

## COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

|            |                   |                          |
|------------|-------------------|--------------------------|
| English    |                   | Welcome                  |
| Español    | <i>Spanish</i>    | Bienvenido/a             |
| Tiếng Việt | <i>Vietnamese</i> | Hân hạnh tiếp đón quý vị |
| 中文         | <i>Chinese</i>    | 歡迎                       |

|            |                   |                     |
|------------|-------------------|---------------------|
| English    |                   | Registration        |
| Español    | <i>Spanish</i>    | Oficina de Registro |
| Tiếng Việt | <i>Vietnamese</i> | Quầy tiếp khách     |
| 中文         | <i>Chinese</i>    | 登記處                 |

|            |                   |               |
|------------|-------------------|---------------|
| English    |                   | Cashier       |
| Español    | <i>Spanish</i>    | Cajera        |
| Tiếng Việt | <i>Vietnamese</i> | Quầy trả tiền |
| 中文         | <i>Chinese</i>    | 收銀部           |

|            |                   |         |
|------------|-------------------|---------|
| English    |                   | Enter   |
| Español    | <i>Spanish</i>    | Entrada |
| Tiếng Việt | <i>Vietnamese</i> | Lối vào |
| 中文         | <i>Chinese</i>    | 入口      |


|            |                   |        |
|------------|-------------------|--------|
| English    |                   | Exit   |
| Español    | <i>Spanish</i>    | Salida |
| Tiếng Việt | <i>Vietnamese</i> | Lối ra |
| 中文         | <i>Chinese</i>    | 出口     |

|            |                   |               |
|------------|-------------------|---------------|
| English    |                   | Restroom      |
| Español    | <i>Spanish</i>    | Baños         |
| Tiếng Việt | <i>Vietnamese</i> | Phòng vệ sinh |
| 中文         | <i>Chinese</i>    | 洗手間           |



 **Point to a sentence**

 **Señale una frase**

 **Xin chỉ vào câu**

 **指向句子**

| <i>Instructions</i>  | <i>Instrucciones</i>   | <i>Chỉ Dẫn</i>  | <i>指示</i>   |
|--|--|---|---|
| <i>We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.</i> | <i>Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.</i> | <i>Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vì muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.</i> | <i>這卡可以幫助大家更明白對方。請指向您想溝通的句子，如有需要，稍後我們可以為您安排傳譯員。</i> |



## COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

| English | Spanish / Español | Vietnamese / Tiếng Việt | CI |
|---------|-------------------|-------------------------|----|
|---------|-------------------|-------------------------|----|

∅ Point to a sentence ∅ Señale una frase ∅ Xin chỉ vào câu ∅

| <i>Courtesy statements</i> | <i>Frases de cortesía</i>      | <i>Từ ngữ lịch sự</i> |      |
|----------------------------|--------------------------------|-----------------------|------|
| Please wait.               | Por favor espere (un momento). | Xin vui lòng chờ.     | 請等等  |
| Thank you.                 | Gracias.                       | Cám ơn.               | 多謝   |
| One moment, please.        | Un momento, por favor.         | Xin đợi một chút.     | 請等一會 |

∅ Point to a sentence ∅ Señale una frase ∅ Xin chỉ vào câu ∅

| <i>Patient may say....</i>           | <i>El paciente puede decir...</i> | <i>Bệnh nhân có thể nói...</i> | 病     |
|--------------------------------------|-----------------------------------|--------------------------------|-------|
| My name is...                        | Mi nombre es ...                  | Tôi tên là...                  | 我的名字是 |
| I need an interpreter.               | Necesito un intérprete.           | Chúng tôi cần thông dịch viên. | 我需要一位 |
| I came to see the doctor, because... | Vine a ver al doctor porque ...   | Tôi muốn gặp bác sĩ vì...      | 我來見醫生 |
| I don't understand.                  | No entiendo.                      | Tôi không hiểu.                | 我不明白  |

|  |                                   |   |                  |
|--|-----------------------------------|---|------------------|
| <b>Patient may say...</b>              | <b>El paciente puede decir...</b> | <b>Bệnh nhân có thể nói...</b>                          | <b>病人可能會說...</b> |
| Please hurry. It is urgent.            | Por favor apúrese. Es urgente.    | Vui lòng nhanh lên. Tôi có chuyên khẩn cấp.             | 請盡快，這是非常緊急。      |
| Where is the bathroom?                 | Dónde queda el baño?              | Phòng vệ sinh ở đâu?                                    | 洗手間在那裏？          |
| How much do I owe you?                 | Cuánto le debo?                   | Tôi cần phải trả bao nhiêu tiền?                        | 我欠您多少錢？          |
| Is it possible to have an interpreter? | Es posible tener un intérprete?   | Có thể nhờ một thông dịch viên đến giúp chúng ta không? | 可否找一位傳譯員？        |

∅ Point to a sentence      ∅ Señale una frase      ∅ Xin chỉ vào câu      ∅ 指向句子

|                                  |   |  |  |
|----------------------------------|---|--|--|
| <b>Staff may ask or say...</b>   | <b>El personal del médico le puede decir...</b> | <b>Nhân viên có thể hỏi hoặc nói...</b>      | <b>職員可能會問或說。。。</b>   |
| How may I help you?              | ¿En qué puedo ayudarle?                         | Tôi có thể giúp được gì?                     | 我怎樣可以幫您呢？  |
| I don't understand. Please wait. | No entiendo. Por favor espere.                  | Tôi không hiểu. Xin đợi một chút.            | 我不明白，請等等。  |
| What language do you prefer?     | ¿Qué idioma prefiere?                           | Quý vị thích dùng ngôn ngữ nào?              | 您喜歡用什麼語言呢：<br><ul style="list-style-type: none"> <li>• Cantonese 廣東話</li> <li>• Mandarin 國語</li> </ul> |
| We will call an interpreter.     | Vamos a llamar a un intérprete.                 | Chúng tôi sẽ gọi thông dịch viên             | 我們會找一位傳譯員。   |
| An interpreter is coming.        | Ya viene un intérprete.                         | Sẽ có một thông dịch viên đến giúp chúng ta. | 傳譯員就快到。  |



**COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)**

| English | Spanish / Español | Vietnamese / Tiếng Việt |
|---------|-------------------|-------------------------|
|---------|-------------------|-------------------------|

| Point to a sentence                      | Señale una frase                                | Xin chỉ vào câu                         | 職員    |
|--|---|---|-------|
| <i>Staff may ask or say...</i>           | <i>El personal del médico le puede decir...</i> | <i>Nhân viên có thể hỏi hoặc nói...</i> |       |
| What is your name?                       | ¿Cuál es su nombre?                             | Quý vị tên gì?                          | 您叫什麼? |
| Who is the patient?                      | ¿Quién es el paciente?                          | Ai là bệnh nhân?                        | 誰是病人? |
| Please write <u>the patient's</u> :      | Por favor escriba, acerca del <u>paciente</u> : | Xin viết lý lịch của <u>bệnh nhân</u> : | 請寫出病歷 |
| Name                                     | Nombre  | Tên                                     | 姓名    |
| Address                                  | Dirección                                       | Địa Chỉ                                 | 地址    |
| Telephone number                         | Número de teléfono                              | Số Điện Thoại                           | 電話號碼  |
| Identification number                    | Número de identificación                        | Số ID                                   | 醫療卡號  |
| Birth date:                              | Fecha de nacimiento:                            | Ngày Sinh:                              | 出生日期  |
| Month/Day/Year                           | Mes/Día/Año                                     | Tháng/Ngày/Năm                          |       |
| <i>Now, fill out these forms, please</i> | <i>Ahora, por favor conteste estas formas.</i>  | <i>Bây giờ xin điền những đơn này.</i>  | 現     |

Ø Point to a sentence

Ø Señale una frase

Ø Lonje dwèt ou sou yon fraz

| <i>Instructions</i>  | <i>Instrucciones</i>   | <i>Esplikasyon</i>  |
|--|--|---|
| <i>We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.</i> | <i>Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.</i> | <i>Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.</i> |



## COMMON SENTENCES IN MULTIPLE LANGUAGES\ (ENGLISH-SPANISH-FRENCH CREOLE)

| English | Spanish / Español | Creole/ Kr |
|---------|-------------------|------------|
|---------|-------------------|------------|

| Point to a sentence                    | Señale una frase                  | Lonje dwèt ou s                |
|--|-----------------------------------|--------------------------------|
| <i>Courtesy statements</i>             | <i>Frases de cortesía</i>         | <i>Pawòl pou Ka</i>            |
| Please wait.                           | Por favor espere (un momento).    | Tanpri, tann (yon moman)       |
| Thank you.                             | Gracias.                          | Mési.                          |
| One moment, please.                    | Un momento, por favor.            | Tann yon moman, tanpri.        |
| <i>Patient may say....</i>             | <i>El paciente puede decir...</i> | <i>Pasyan an ka</i>            |
| My name is.....                        | Mi nombre es .....                | Non mwen se....                |
| I need an interpreter.                 | Necesito un intérprete.           | Mwen bezwen yon entèpt         |
| I came to see the doctor, because .... | Vine a ver al doctor porque ..... | Mwen vin wè doktè a, paske.... |
| I don't understand.                    | No entiendo.                      | Mwen pa konprann.              |
| Please hurry. It is urgent.            | Por favor apùrese. Es urgente.    | Tanpri ÿ vit. Sa ijan.         |
| Where is the bathroom?                 | Dónde queda el baño?              | Kote twaît la yo?              |
| How much do I owe you?                 | Cuánto le debo?                   | Konbyen pou mwen peye?         |
| Is it possible to have an interpreter? | Es posible tener un intérprete?   | ske mwen ka gen yon entèpt?    |

|                                   |   |   |
|-----------------------------------|---|---|
| <i>Staff may ask or say....</i>   | <i>El personal del médico le puede decir...</i> | <i>Anplwaye medikal la kapab di oubyen mande...</i> |
| Please hold. I will be right back | Por favor espere un momento. Ya regreso.        | Tanpri, tann yon moman. M ap tounen touswit.        |
| How may I help you?               | ¿En qué puedo ayudarle?                         | Kisa mwen ka f pou ou?                              |
| I don't understand. Please wait.  | No entiendo. Por favor espere.                  | Mwen pa komprann. Tanpri, tann yon moman.           |
| What language do you prefer?      | ¿Qué idioma prefiere?                           | Ki lang ou pito?                                    |
| We will call an interpreter.      | Vamos a llamar a un intérprete.                 | Nou pral rele yon enfpit.                           |
| An interpreter is coming.         | Ya viene un intérprete.                         | Gen yon enfpit ki nan wout.                         |
| What is your name?                | ¿Cuál es su nombre?                             | Kouman ou rele?                                     |
| Who is the patient?               | ¿Quién es el paciente?                          | Ki moun ki pasyan an?                               |



## COMMON SENTENCES IN MULTIPLE LANGUAGES\ (ENGLISH-SPANISH-FRENCH CREOLE)

| English                                  | Spanish / Español                               | Creole/ Krey                            |
|--|---|---|
| Ø Point to a sentence                    | Ø Señale una frase                              | Ø Lonje dwèt ou sou                     |
| <i>Staff may ask or say....</i>          | <i>El personal del médico le puede decir...</i> | <i>Anplwaye medikal la kapab...</i>     |
| Please write <u>the patient's</u> :      | Por favor escriba, acerca <u>del paciente</u> : | Tanpri, ekri enfimasyon sa yo <u>po</u> |
| Name                                     | Nombre  | Non                                     |
| Address                                  | Dirección                                       | Adr̃s                                   |
| Telephone number                         | Número de teléfono                              | Nimewo telefòn                          |
| Identification number                    | Número de identificación                        | Nimewo didantite                        |
| Birth date:                              | Fecha de nacimiento:                            | Dat nesans:                             |
| Month / Day / Year                       | Mes / Día / Año                                 | Mwa / Jou                               |
| <i>Now, fill out these forms, please</i> | <i>Ahora, por favor conteste estas formas.</i>  | <i>Koulye a, ekri enfimasyon yo ma</i>  |





## **EMPLOYEE LANGUAGE PRE-SCREENING TOOL**

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

**Printer friendly version of the EMPLOYEE  
LANGUAGE PRE SCREENING TOOL KIT  
provided on next page.**

### EMPLOYEE LANGUAGE PRE SCREENING TOOL KEY

| <b>Key Spoken Language</b>            |   |
|---------------------------------------|---|
| (1)                                   | Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.   |
| (2)                                   | Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.  |
| (3)                                   | Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.  |
| (4)                                   | Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.  |
| (5)                                   | Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.   |
| <b>Key Reading</b>                    |   |
| (1)                                   | No functional ability to read. Able to understand and read only a few key words.  |
| (2)                                   | Limited to simple vocabulary and sentence structure.  |
| (3)                                   | Understands conventional topics, non-technical terms and health care terms.   |
| (4)                                   | Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.   |
| (5)                                   | Understands sophisticated materials, including those related to academic, medical and technical vocabulary.   |
| <b>Key Writing</b>                    |   |
| (1)                                   | No functional ability to write the language and is only able to write single elementary words.  |
| (2)                                   | Able to write simple sentences. Requires major editing.   |
| (3)                                   | Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.   |
| (4)                                   | Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.   |
| (5)                                   | Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.  |
| <b>Interpretation vs. Translation</b> | <p><b>Interpretation:</b> Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor.</p> <p><b>Translation:</b> Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original.</p> <p><i>Source: University of Washington Medical Center</i></p> |



**EMPLOYEE LANGUAGE PRESCREENING TOOL  
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)**

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: \_\_\_\_\_ Department/Job Title: \_\_\_\_\_  
\_\_\_\_\_

Work Days: Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun Work Hours (Please Specify): \_\_\_\_\_  
\_\_\_\_\_

**Directions:** (1) List any/all language(s) or dialects you know.  
(2) Indicate how fluently you speak, read and/or write each language

| Language | Dialect, region, or country | Fluency: see attached key<br>(Circle) |           |           | I would like to use my language skills to speak with patients<br>(Circle) | I would like to use my reading language skills to communicate with patients<br>(Circle) | I would like to use my language skills to write patient communications<br>(Circle) |
|----------|-----------------------------|---------------------------------------|-----------|-----------|---|---|--|
|          |                             | Speaking                              | Reading   | Writing   | Yes No  | Yes No  | Yes No   |
| 1.       |                             | 1 2 3 4 5                             | 1 2 3 4 5 | 1 2 3 4 5 | Yes No  | Yes No  | Yes No   |
| 2.       |                             | 1 2 3 4 5                             | 1 2 3 4 5 | 1 2 3 4 5 | Yes No  | Yes No  | Yes No   |
| 3.       |                             | 1 2 3 4 5                             | 1 2 3 4 5 | 1 2 3 4 5 | Yes No  | Yes No  | Yes No   |
| 4.       |                             | 1 2 3 4 5                             | 1 2 3 4 5 | 1 2 3 4 5 | Yes No  | Yes No  | Yes No   |

**TO BE SIGNED BY THE PERSON COMPLETING THIS FORM**

I, \_\_\_\_\_, attest that the information provided above is accurate.

Date: \_\_\_\_\_



## SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

| Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors   |
|---|
| <b>General Business Requirements Questions</b>  |
| 1. What geographic areas do you currently serve?  |
| 2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).   |
| 3. Is your company aware and automatically follow special certifications for states you provide services in/for?  |
| 4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from. |
| 5. Please list the 3-5 most common languages your organization translates.  |
| 6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?                                      |
| 7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?  |
| 8. Please list all national states and global countries you provide Services in.  |
| 9. What differentiates your company from your competition as it relates to the services outlined in this RFP?   |
| 10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.  |
| 11. Is your company able to assign dedicated resource team to support services?   |
| 12. What percent of your current business is providing services within the health care industry?  |
| 13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.  |
| 14. Do you use validated test instruments to assess your medical or health care terminology translators?  |
| 15. Do you support the most recent version of InDesign?   |
| 16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?  |
| 17. Can you produce translations on any day of the year?  |
| 18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.   |
| 19. Please demonstrate how your company was flexible with an unusual client request.  |
| 20. What is your process to work with document owners to fine tune translations to match their specific target audience?  |



| <b>Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors</b>  |
|---|
| 21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)   |
| 22. Are you open to the total translation memory being provided to us (health plan) upon request?   |
| 23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?  |
| <b>Administration Questions</b>   |
| 1. What are your standard hours of operation?   |
| 2. Do you have a privacy and confidentiality policy? If yes, please describe.   |
| 3. What are your policies regarding direct contact between a translator and the client?   |
| 4. What is the average amount of time to complete a translated document from receipt to delivery?   |
| 5. How much advance notice is needed to request translation services?   |
| <b>Customer Service Questions</b>   |
| 1. Please describe your Customer Service model for these services.  |
| 2. Please describe the grievance and complaint escalation process and resolution of service issues?   |
| 3. What is the experience level of project management team with localization and cultural adaptation?   |
| 4. What is the coverage of services for different time zones?   |
| 5. Do you provide full or partial services on holidays and weekends?  |
| 6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.                       |
| 7. Please explain your capabilities to ensure cultural adaptation.  |
| <b>Service Level Questions</b>  |
| 1. Please list and describe your standard Service Levels. You may attach them separately.   |
| 2. Do you offer service guarantees? If yes, please provide.   |
| <b>Translation Services Questions</b>   |
| 1. How long has your company been providing Translation Services as part of its offering?   |
| 2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.                                    |
| 3. Please translate the provided document labeled "XXXX"  |
| <b>Quality Assurance Practices/Proficiencies Questions</b>  |
| 1. Please describe the process for screening potential interpreters and translators.  |
| 2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others? |
| 3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?                 |



**Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors**

|   |
|---|
| 4. Please indicate which of the following skills are evaluated in an initial screening or translators:<br><input type="checkbox"/> Basic Language Skills<br><input type="checkbox"/> Cultural Awareness<br><input type="checkbox"/> Written Translation Skills<br><input type="checkbox"/> Industry Specific Terminology<br><input type="checkbox"/> Ethics<br><input type="checkbox"/> Others (Please explain) |
| 5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.  |
| 6. Is continuing education required? If yes, how many hours per year?   |
| 7. What percentage of your translators are certified by:<br><input type="checkbox"/> Internal Process<br><input type="checkbox"/> Federal Court<br><input type="checkbox"/> State Process<br><input type="checkbox"/> Private External Organization (please list)   |
| 8. Describe your internal quality control or monitoring process.  |
| 9. What system do you have in place to resolve complaints?  |
| 10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?  |
| 11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.  |
| 12. Please list all certifications and all other QM certifications your company holds/maintains.  |
| 13. Please describe your Quality Assurance program.   |
| 14. How often does your company review and revise the quality program?  |
| 15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?   |
| 16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.  |
| 17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original   |
| 18. How long has your company been providing Proficiency and Certification Services as part of its offering?  |
| 19. Please provide an overview of your Proficiency and Certification Service program.   |
| 20. Does your program include examination of general language usage in formal and professional context? Please Define.  |
| 21. Does your program include examination of fluency in the assessment language?  |
| 22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry   |
| 23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.  |



| <b>Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors</b> |   |
|--|---|
| <b>Experience Questions</b>  |   |
| 1.   | How long have you been in business?   |
| 2.   | Please provide at least three references.   |
| 3.   | Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.   |
| 4.   | Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?   |
| 5.   | How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?   |
| 6.   | Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.   |
| 7.   | Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.  |
| 8.   | Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits. |
| 9.   | Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?   |
| <b>Reporting Questions</b>   |   |
| 1.   | Do you offer a standard reporting package? If yes, please attach.   |
| 2.   | Do you provide reports confirming language proficiency of employees or contractors that provide services?   |
| <b>Fee Questions</b>   |   |
| 1.   | Please describe your pricing practices and fee schedule.  |
| 2.   | Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?  |
| 3.   | What kind of volume discounts do you offer?   |
| 4.   | Do you offer services on a single use basis?  |
| 5.   | What information is provided on billing statements? Please include a sample.  |



**Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors**

|   |
|---|
| 6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators:<br><input type="checkbox"/> Simplified Chinese for China<br><input type="checkbox"/> Canadian French<br><input type="checkbox"/> Brazilian Portuguese<br><input type="checkbox"/> Japanese<br><input type="checkbox"/> Russian<br><input type="checkbox"/> Argentine Spanish |
| 7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators:<br><input type="checkbox"/> Simplified Chinese for China<br><input type="checkbox"/> Canadian French<br><input type="checkbox"/> Brazilian Portuguese<br><input type="checkbox"/> Japanese<br><input type="checkbox"/> Russian<br><input type="checkbox"/> Argentine Spanish |
| 8. What guarantees are available if the work produced does not meet our expectations?   |
| 9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?  |
| 10. Are your prices the same for all languages; common and rarely spoken?   |
| 11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?   |
| 12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.   |
| 13. Do you provide pricing for leveraged (previously translated) words?   |
| 14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?  |
| 15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?   |
| <b>Technology Questions</b>   |
| 1. Do you use a submission portal? If so, is all communication via the submission portal?   |
| 2. What technology is used to manage translation memory?  |





**SECTION C: RESOURCES TO INCREASE AWARENESS OF  
CULTURAL BACKGROUNDS AND ITS IMPACT ON  
HEALTH CARE DELIVERY**

## A GUIDE TO INFORMATION IN SECTION C

### Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

#### The following materials are available in this section:

|  |  |
|--|--|
| <b>What is Health Disparities/Health Equity?</b>                       | A detailed description of Health Disparities   |
| <b>Let's Talk About Sex</b>  | A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information. |
| <b>Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)</b> | A guide to the Lesbian, Gay, Bisexual or Transgender communities.  |
| <b>Cultural Background – Information on Special Topics</b>             | Points of reference to become familiar with diverse cultural backgrounds.  |
| <b>Effectively Communicating with the Elderly</b>                      | A tip sheet on how to better communicate with elderly patients.  |
| <b>Pain Management Across Cultures</b>                                 | A guide to help you understand the ways people may use to describe pain and approach to treatment options.   |

## HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

### What does health equity mean?

**Health Equity is attainment of the highest level of health for all people.**

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: [http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_05\\_Section1.pdf](http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf)

### What are health disparities and why do they matter to all of us?

**A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.**

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: <http://minorityhealth.hhs.gov/npa>

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities...

**Example 1:** *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

**Example 2:** *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*



## The Difference between Health Equality and Health Equity

**Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive**

**Equality** denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: <http://www.differencebetween.net/language/difference-between-equity-and-equality>

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, <http://www.who.int/healthsystems/topics/equity>

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

## Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

### How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit <https://www.thinkculturalhealth.hhs.gov>

### Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

**As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.**

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website <https://www.thinkculturalhealth.hhs.gov>, sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

**You may access free and accredited continuing education programs** as well as tools to help you and your organization provide respectful, understandable and effective services.

**Source: Think Cultural Health (TCH)**, <https://www.thinkculturalhealth.hhs.gov> **Think Cultural Health** is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of **Think Cultural Health** is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services

### Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):



- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority <http://minorityhealth.hhs.gov>

### Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, <http://minorityhealth.hhs.gov/npa>
- Offices of Minority Health at HHS, <http://minorityhealth.hhs.gov>
- Think Cultural Health, <https://www.thinkculturalhealth.hhs.gov>

## LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

| Areas of Cultural Variation                          | Points To Consider   | Suggestions   |
|--|--|---|
| <b>Gender Roles</b>                                  | <ul style="list-style-type: none"> <li>Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age).</li> <li>A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider).</li> <li>Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person.</li> <li>Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.</li> </ul>  | <ul style="list-style-type: none"> <li>Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam.</li> <li>As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times.</li> <li>Use same sex non-family members as interpreters.</li> </ul> |
| <b>Sexual Health and Patient Cultural Background</b> | <ul style="list-style-type: none"> <li>If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related.</li> <li>In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition.</li> <li>Example: Chinese males may discuss sexual performance problems in terms of a “weak liver.</li> <li>Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place.</li> <li>Printed materials on topics of sexual health may be considered inappropriate reading materials.</li> </ul> | <ul style="list-style-type: none"> <li>Explain to the patient why you are requesting sexually related information at that time.</li> <li>For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information.</li> <li>Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient</li> </ul>  |



| Areas of Cultural Variation               | Points To Consider   | Suggestions  |
|---|--|--|
| <p><b>Confidentiality Preferences</b></p> | <ul style="list-style-type: none"> <li>• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed.</li> <li>• A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials.</li> <li>• Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.</li> </ul> | <ul style="list-style-type: none"> <li>• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity.</li> <li>• Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information."</li> <li>• Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.</li> </ul> |

## LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)<sup>1</sup> may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

**According to Healthy People 2020<sup>2</sup>, LGBT health disparities include:**

### Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

### Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.



Visit [glma.org](http://glma.org) for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit [glaad.org](http://glaad.org) for additional resources on how to fairly and accurately report on transgender people

<sup>1</sup> The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

<sup>2</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>





Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

#### **Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery**

- [GLMA cultural competence webinar series](#)
- [Providing Enhanced Resources Cultural Competency Training](#)
- [LGBT Health Resources](#)
- [Equal Employment Opportunity Commission](#) for your local EEOC field office
- [Creating an LGBT Friendly Practice](#)
- [LGBT Training Curricula for Behavioral Health and Primary Care Practitioners](#)
- [Preventing Discrimination](#)
- [Bullying Policies & Laws](#)

## CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

### Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.



- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and “medicines” that are considered “folk” medicine or “herbal” medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are “hard to find” or that are purchased “at special stores” may get you a more accurate understanding of what people are using than asking about **“alternative,” “traditional,” “folk,” or “herbal” medicine.**

### Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.



- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

## Weight

- In many poor countries, and among people who come from them, “chubby” children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

## Infant Health

- It is very important to avoid making too many positive comments about a baby’s general health.
  - Among traditional Hmong, saying a baby is “pretty” or “cute” may be seen as a threat because of fears that spirits will be attracted to the child and take it away
  - Some traditional Latinos will avoid praise to avoid attracting the “evil eye”
  - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother’s care – “the baby looks like you take care of him well.”
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child’s experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

## Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.



- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient’s culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.



## Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable [here](#), and what may cause physical harm.
- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.
- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.
- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.
- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.
- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

### Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.



## EFFECTIVELY COMMUNICATING WITH THE ELDERLY

| Older Adult Communication from Your Patients Perspective   |   |
|--|---|
| I Wish You Knew...   | I Wish You Would Do...  |
| <i>I want to be respected and addressed formally. I appreciate empathy.</i>  | Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.  |
| <i>I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.</i>        | Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.   |
| <i>I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.</i>                                     | When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible   |
| <i>I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.</i>   | Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)  |
| <i>Medical jargon and acronyms confuse me.</i>   | Use layperson language, not acronyms or popular slang terms.  |
| <i>I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.</i>  | Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.  |
| <i>Nodding my head doesn't always mean I understand,</i>   | Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.  |
| <i>I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.</i> | Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.   |
| <i>Some topics such as advance directives or a terminal prognosis are very sensitive for me.</i>   | <p>Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me.</p> <p>Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.</p> |



## Resources

- The Gerontological Society of America  
[http://aging.arizona.edu/sites/aging/files/activity\\_1\\_reading\\_1.pdf](http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf)
- American Speech Language Hearing Association  
<http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/>
- Administration for Community Living DHHS  
[http://www.aoa.acl.gov/AoA\\_Programs/Tools\\_Resources/Older\\_Adults.aspx](http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx)
- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program  
[http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204\\_GDS\\_I\\_Reference%20Guide.pdf](http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDS_I_Reference%20Guide.pdf)

## PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

**These tips are generalizations only. It is important to remember that each patient should be treated as an individual.**

| Areas of Cultural Variation  | Points to Consider  | Suggestions   |
|--|---|---|
| <b>Reaction to pain and expression of pain</b>                     | <ul style="list-style-type: none"> <li>• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain.</li> <li>• Some men may not verbalize or express pain because they believe their masculinity will be questioned.</li> </ul>  | <ul style="list-style-type: none"> <li>• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm.</li> <li>• Because the expression of pain varies, <b>ask</b> the patient what level, or how much, pain relief they think they need.</li> <li>• Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.</li> </ul>                         |
| <b>Spiritual and religious beliefs about using pain medication</b> | <ul style="list-style-type: none"> <li>• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief.</li> <li>• Other religious traditions forbid the use of narcotics.</li> <li>• Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.</li> </ul> | <ul style="list-style-type: none"> <li>• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices.</li> <li>• Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment.</li> <li>• Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.</li> </ul> |
| <b>Beliefs About Drug Addiction</b>                                | <ul style="list-style-type: none"> <li>• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population.</li> <li>• Past negative experience with pain medication shapes current community beliefs, even if the</li> </ul>  | <ul style="list-style-type: none"> <li>• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact.</li> <li>• Explain how the determination of type and amount of medication is made. Explain changes from past practices.</li> </ul>  |



|                                      |   |  |
|--------------------------------------|---|--|
|                                      |   | <ul style="list-style-type: none"> <li>• what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them.</li> <li>• Accommodate or integrate your treatments with alternative treatments when possible.</li> </ul>  |
| <b>Methods Needed to Assess pain</b> | <ul style="list-style-type: none"> <li>• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.</li> </ul> | <ul style="list-style-type: none"> <li>• Ask the patient specifically how they can best describe their pain.</li> <li>• Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results.</li> <li>• Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques.</li> <li>• Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.</li> </ul> |

\* **Note:** Avoid using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.



**SECTION D: REFERENCE RESOURCES FOR CULTURALLY  
AND LINGUISTIC SERVICES**

## A GUIDE TO INFORMATION IN SECTION D

### Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

### Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report *Unequal Treatment* that intersect to perpetuate health disparities (IOM, 2003).<sup>1</sup>

### Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.<sup>1</sup>

### This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

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<sup>1</sup> <https://www.thinkculturalhealth.hhs.gov/>



The following materials are available in this section:

|   |   |
|---|---|
| <b>45 CFR 92, Non Discrimination Rule</b>   | Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).  |
| <b>Title VI of the Civil Rights Act of 1964</b>                                       | The Civil Rights Act of 1964 text.  |
| <b>Standards to Provide “CLAS” Culturally and Linguistically Appropriate Services</b> | A summary of the fifteen “CLAS” standards.  |
| <b>Executive Order 13166, August 2000</b>   | The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs. |
| <b>Race/Ethnicity/Language (REL) Categories</b>                                       | Importance of collecting REL and appropriate use.   |
| <b>Bibliography of Major Sources Used in the Production of the Tool Kit</b>           | A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.   |
| <b>Cultural Competence Web Resources</b>  | A listing of internet resources related to diversity and the delivery of cultural and linguistic services.  |
| <b>Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup</b> | A listing of the contributors from the ICE Cultural and Linguistic Workgroup.   |

## 45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201 (a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

## TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

**“No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”**



Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring “meaningful access” to healthcare, and “equal care” for all patients. Other federal and state legislation protecting the right to “equal care” outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.



Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued “Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency.” This policy established ‘national origin’ as applying to limited English-speaking recipients of federally funded programs.

## NATIONAL STANDARDS TO PROVIDE “CLAS” CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

### Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

### Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

### Communication and Language Assistance:



5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

### Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.



10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.





## **EXECUTIVE ORDER 13166, AUGUST 2000**

### **Improving Access to Services for Persons with Limited English Proficiency (Verbatim)**

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

#### **Section 1. Goals.**

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

#### **Sec. 2. Federally Conducted Programs and Activities.**

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

#### **Sec. 3. Federally Assisted Programs and Activities.**

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.



The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

**Sec. 4. Consultations.**

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

**Sec. 5. Judicial Review.**

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: <http://www.usdoj.gov/crt/cor/Pubs/eolep.htm>

## RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.

The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

### Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other"

### Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. \*OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

Source: [www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

Reference: <http://www.usdoj.gov/crt/cor/Pubs/eolep.htm>

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[www.cms.hhs.gov/healthplans/opl/opl133.pdf](http://www.cms.hhs.gov/healthplans/opl/opl133.pdf): Department of Health and Human Services Centers for Medicare & Medicaid Services. *Operational Policy Letter #: OPL 2001.133*. July 16, 2001.

[www.differencebetween.net/language/difference-between-equity-and-equality](http://www.differencebetween.net/language/difference-between-equity-and-equality)

[www.dictionary.com/browse/teletypewriter?s=t](http://www.dictionary.com/browse/teletypewriter?s=t)

[www.ecfr.gov/cgi-bin/text-idx?node=sp45.1.92.c#se45.1.92\\_1201](http://www.ecfr.gov/cgi-bin/text-idx?node=sp45.1.92.c#se45.1.92_1201)

[www.erc.msh.org](http://www.erc.msh.org): Management Sciences for Health. *Culturally Competent Organizations. CLAS Standards*. (2003).

[www.glma.org](http://www.glma.org)

[www.hablamosjuntos.org/signage/symbols/default.using\\_symbols.asp#bpw](http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw)



[www.healthypeople.gov/2020/about/foundation-health-measures/Disparities](http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities)

www.lep.gov: Department of Justice, Civil Rights Division, Executive Order 13166.  
Information and Guidance for Recipients of Federal Funds on Language Access to Federally Assisted  
Programs and Activities. (2003).

[www.npsf.org/?page=askme3](http://www.npsf.org/?page=askme3)

[www.thinkculturalhealth.hhs.gov](http://www.thinkculturalhealth.hhs.gov)

[www.thinkculturalhealth.hhs.gov/clas/standards](http://www.thinkculturalhealth.hhs.gov/clas/standards)

www.usdoj.gov/crt/cor/Pubs/eolep.htm: Department of Justice, Civil Rights Division, Executive Order  
13166. Improving Access to Services for Persons with Limited English Proficiency. Verbatim as released by  
the Office of the Press Secretary, The White House (August 11, 2000).

[www.usdoj.gov/crt/cor/Pubs/eolep.htm](http://www.usdoj.gov/crt/cor/Pubs/eolep.htm)

[www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

[www.who.int.healthsystems/topics/equity](http://www.who.int.healthsystems/topics/equity)



## CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services  
- Think Cultural Health

<https://www.thinkculturalhealth.hhs.gov>

Diversity RX

<http://diversityrx.org/resources>

Institute for Healthcare Improvement

<http://www.ihp.org/Pages/default.aspx>

U.S. Department of Health and Human Services - Office of Minority Health

<http://www.minorityhealth.hhs.gov/>

Cross Cultural Health Care Program

<http://xculture.org>

National Institute of Health

<https://www.nih.gov>

U.S. Department of Health and Human Services  
– Health Resources and Services Administration

<http://www.hrsa.gov/culturalcompetence/index.html>

Provider's Guide to Quality & Culture

<http://www.msh.org/resources/providers-guide-to-quality-culture>

U.S. Department of Justice – Civil Rights Division

<https://www.justice.gov/crt>

National Center for Cultural Competence –  
Georgetown University

<http://www.ncccurricula.info/awareness/C7.html>

Industry Collaboration Effort (ICE)

<http://iceforhealth.org/aboutice.asp>

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**Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.**



## **GLOSSARY OF TERMS**

### Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

### American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

### American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

### Barrier

an obstacle, impediment, obstruction, boundary, or separation.

### Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

### Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

### Communication

the sending of data, messaged, or other forms of information from one entity to another.

### Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

### Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

### Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

### Culture

shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

### Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

### Disability

any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

### Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

### Diverse

of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

### Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

### Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

### Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

### Health Equity

an avoidable and unfair difference in health status between segments of the population.

### Health Literacy

the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation

In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter

one who translates orally for parties conversing in different languages.

Language

the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)

is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic

Anything intended to aid memory.

Race

the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource

an asset valuable commodity or service.

Service

help or assistance.

Speech

the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator

a person trained to recognize unclear speech and repeat it clearly

Teletypewriter

a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender

an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.



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## Guidance to Comply with New Interpreter Quality Standards Requirements on the use of Bilingual/Multilingual Staff as Interpreters

| <b><u>Summary of Requirements and Documentation</u></b>  |  |  |
|--|--|--|
| <b>Requirement</b>   | <b>Potential Evidence</b>  | <b>Provider Office to Note Documentation of Qualification</b>  |
| <b>Office has a documented policy to offer interpreter support to LEP patients</b>   | <input type="checkbox"/> Local office written policy; or<br><input type="checkbox"/> Local office policy that defers and adheres to the policy distributed by medical group<br>Note: Policy includes documentation of patient language needs in medical record   | Written policy available for viewing by an auditor<br><br>Policy title:  |
| <b>Adheres to generally accepted interpreter ethics principles, including client confidentiality</b>   | Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at:<br><br><a href="http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf">http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf</a>   | Signed attestations are available.<br><input type="checkbox"/> Yes<br><br><input type="checkbox"/> No  |
| <b>Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language</b>   | <input type="checkbox"/> Formal assessment of proficiency; or<br><br><input type="checkbox"/> Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language   | <input type="checkbox"/> Yes, assessment results are available for viewing; or<br><input type="checkbox"/> Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available |
| <b>Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology</b>   | <input type="checkbox"/> Formal assessment of proficiency; or<br><br>Annual performance evaluations document<br><input type="checkbox"/> Ability to interpret effectively,<br><input type="checkbox"/> Ability to interpret accurately,<br><input type="checkbox"/> Ability to interpret impartially,<br><input type="checkbox"/> Ability to interpret receptively and expressly,<br><input type="checkbox"/> Ability to interpret to and from English and another language using any <b><u>necessary specialized vocabulary terminology and phraseology</u></b><br><br>Note: see NCIHC Interpreter Code of Ethics for description of above. | <input type="checkbox"/> Yes, assessment results are available for viewing; or<br><input type="checkbox"/> Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available |
| <p><b>For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D.</b></p> <p><a href="http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf">http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf</a></p> |  |  |

## Language Proficiency Assessment Resources

The bilingual assessment vendors included on this list are suggestions that providers might consider if they choose to use a bilingual assessment vendor to help ensure that they are using qualified bilingual staff to provide patient care, as these organizations have self-attested that they meet the required criteria. However, that should not be considered an endorsement for any language service vendor by ICE. The ICE C&L Team has not in the past and does not now endorse any language service vendors.

| Language Proficiency Assessment Resources   |   |  |  |  |  |  |
|---|---|--|--|--|--|--|
| Description & Types of Services   |   |  |  |  |  |  |
| Organization  | Website / Contact Information   | # of Offered Languages   | Custom to Medical Specialty  | Assessments  | Certification &/or Experience  | Cost   |
| <b>Berkeley Language Institute (BU)</b><br>Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).             | <a href="http://www.berkeleylanguageinstitute.com/index.html">http://www.berkeleylanguageinstitute.com/index.html</a><br><br>1-510-655-9469<br><br>Marci Valdivieso<br><a href="mailto:marci@berkeleylanguageinstitute.com">marci@berkeleylanguageinstitute.com</a>   | <b>8 languages offered:</b><br>Arabic, Chinese (Mandarin, Cantonese, and Taishanese/Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese   | Yes  | <ul style="list-style-type: none"> <li>Professional language assessments for interpreters, translators, &amp; bilingual speakers</li> <li>Language Proficiency Oral Assessment – ideal for current &amp; pre-employment bilingual employees</li> <li>Language Proficiency Written Assessment</li> <li>Medical Staff Oral Assessment</li> <li>Healthcare Interpreter Assessments</li> </ul>                         | Evaluators are experienced linguists that have: <ul style="list-style-type: none"> <li>At least five years interpreter &amp; translator experience</li> <li>Have shown an aptitude to be language evaluators.</li> <li>They are generally certified by/with the National Board or CCHI if the language pair is an option, or</li> <li>They are otherwise assessed and trained prior to being given evaluation assignments</li> </ul> | Cost will vary depending on language pair and type of assessment<br>\$115 - \$190/ person                            |
| <b>Culture Advantage</b><br>Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.   | <a href="https://cultureadvantage.org/">https://cultureadvantage.org/</a><br><br>1-316-217-0198<br><br>Marlene Obermeyer, MA, RN<br><a href="mailto:director@cultureadvantage.org">director@cultureadvantage.org</a>  | <b>10 languages offered:</b><br>Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese   | Yes<br>All medical specialties offered in the professional program | <ul style="list-style-type: none"> <li>Bilingual Staff Medical Interpreting Skills Assessment (MISA)</li> <li>Specialty-specific Medical Interpreting Skills Assessment</li> </ul>   | Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair  | Cost will vary \$200 /MISA<br>\$250 - \$950 for Online Courses   |
| <b>ISI Language Solutions</b><br>ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations. | <a href="https://isilanguagesolutions.com/industries/healthcare/">https://isilanguagesolutions.com/industries/healthcare/</a><br><br>1-818-753-9181<br><br>John Lopez<br><a href="mailto:john@isitrans.com">john@isitrans.com</a><br><br>Christina Xu<br><a href="mailto:christina@isitrans.com">christina@isitrans.com</a> | <b>22 languages offered:</b><br>Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese | No   | <ul style="list-style-type: none"> <li>Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole                             <ul style="list-style-type: none"> <li>Language Proficiency Assessment</li> <li>Building Cultural Competency Workshop</li> <li>Medical Terminology Workshop</li> <li>Medical Interpreting Ethics and Protocol Workshop</li> </ul> </li> </ul> | Professional Linguists <ul style="list-style-type: none"> <li>Certification or Accreditation from American Translators Association (ATA) or equivalent organization</li> <li>Degree in Translation or foreign equivalent</li> <li>Subject-Matter expertise in the field of Life Sciences</li> <li>Extensive experience in translation and linguistics</li> </ul>   | Must contact for costs<br><br>Cost example: <ul style="list-style-type: none"> <li>Flat rate/ test - \$80</li> </ul> |



| Language Proficiency Assessment Resources  |   |  |  |   |   |   |
|--|---|--|--|---|---|---|
| Description & Types of Services  |   |  |  |   |   |   |
| Organization   | Website / Contact Information   | # of Offered Languages   | Custom to Medical Specialty  | Assessments   | Certification &/or Experience   | Cost  |
| <b>Language Line Academy (LLA)</b><br>Our professional testing and training ensures the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.  | <a href="https://www.languageonline.com/">https://www.languageonline.com/</a><br>1-844-552-8378<br>Ana Catalina Arguedas<br>Fernández<br><a href="mailto:la@languageonline.com">la@languageonline.com</a>                                   | <b>1 language offered:</b><br>Spanish  | Yes<br>Pediatrics<br>Mental Health<br>OB/Gyn<br>Ophthalmology<br>Gastroenterology<br>Oncology<br>Cardiology<br>Pharmacy  | <ul style="list-style-type: none"> <li>Healthcare Bilingual Fluency assessment for clinicians and medical staff</li> <li>Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour</li> <li>Interpreter Readiness Assessment</li> <li>Interpreter Skills Test</li> </ul>  | LLA testers have a variety of qualifications, including: <ul style="list-style-type: none"> <li>M.A., Translation &amp; Interpretation</li> <li>Years of medical interpreting experience</li> <li>External interpreter certification credentials</li> </ul> | Cost will vary<br>\$145 - \$160/ test<br>Volume discounts available   |
| <b>Language Testing International (LTI)</b><br>In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests. | <a href="https://www.languagetesting.com/">https://www.languagetesting.com/</a><br>1-800-486-8444<br>Marketing/Scheduling Team<br>Diane ext. 123<br>Dina ext. 127<br><a href="mailto:info@languagetesting.com">info@languagetesting.com</a> | <b>100+ languages offered,</b><br>most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish | Offers general testing/ proficiency assessments<br>Does not specifically assess proficiency for healthcare interpretation or translation services                            | <ul style="list-style-type: none"> <li>Oral Proficiency Interview</li> <li>15 – 30 minute telephonic interview</li> <li>Oral Proficiency Interview – Computer</li> <li>20 – 40 minute on-demand, internet or phone-delivered proficiency test</li> <li>Writing Proficiency Test via the web</li> <li>20 – 80 minutes</li> <li>Listening Proficiency Test</li> <li>50 – 125 minutes</li> <li>Reading Proficiency Test</li> <li>50 – 125 minutes</li> </ul> | LTI strictly uses<br>Certified ACTFL testers and raters<br>Ensuring quality and validity of tests   | Contact for costs<br>Package options available for some languages<br>Cost examples:<br>• \$100 - \$200/ person for phone survey<br>• \$159 for web based proctoring |
| <b>MasterWord</b><br>For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.         | <a href="https://www.masterword.com/">https://www.masterword.com/</a><br>1-866-716-4999<br><a href="mailto:masterword@masterword.com">masterword@masterword.com</a>   | <b>250+ languages offered</b><br>for interpreting and translation<br><b>Contact for languages offered for proficiency assessments</b>                  | Not specified<br>Offers On Demand training & Webinars for Healthcare, includes:<br>• Maternal Fetal Medicine<br>• Cardiology<br>• Mental Health<br>• Oncology<br>• Emergency | <ul style="list-style-type: none"> <li>Language Proficiency Assessment: 60 minutes</li> <li>Contact for languages</li> <li>Health Care Interpreter Assessment (HCA<sup>®</sup>): 32 min / 45 min. –oral / written</li> </ul> Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.          | Assessments based on formats of CCHI & NBCMII national certification exams  | On Demand Assessments:<br>\$105 - \$155   |

# COMMUNICATIONS TOOL KIT



This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).



We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes

either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

| <b>Exclusionary</b>   | <b>Inclusive</b>  |
|---|---|
| his, her, his or her, his/her   | their, the members  |
| he, she, he or she, he/she  | they, the members   |
| him, her, him or her, him/her   | them  |
| himself, herself, himself or herself  | themselves  |
| woman, man, men or women  | the member or the individual, members or individuals  |
| gender specific screenings – well-woman etc.  | take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram..." and instead should say "members should have a mammogram" etc.   |
| pregnant women, pregnant woman  | pregnant individuals, child-bearers, child-bearer   |
| mother, father , mom, dad   | parent as applicable  |
| maternity   | excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable  |
| Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity...gender identities. | When need to know sex – include sex terms: male, female, or intersex<br>When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available.<br><br>Consider asking "sex assigned at birth" and "gender identity" to be more inclusive. |
| both sexes  | for sex there is male, female, intersex<br>if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")   |

| <b>Offensive/Insensitive</b>               | <b>Sensitive</b>  |
|--|---|
| hearing impaired                           | deaf or hard of hearing   |
| visual impairment                          | blind or low vision   |
| LEP members                                | members with limited English proficiency  |
| gender reassignment surgery, sex change    | gender affirming surgery, transition  |
| sexual preference                          | sexual orientation  |
| hermaphrodite, hermaphroditism             | "intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"   |
| transgenders, a transgender, transgendered | Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest. |

For additional questions on creating culturally sensitive materials:  
email [Ivy Diaz at ivy.diaz@healthnet.com](mailto:ivy.diaz@healthnet.com) or Peggy Payne, ICE Co-Chair at [peggy.payne@cigna.com](mailto:peggy.payne@cigna.com)

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23-1072/BKT1255857EH02w (9/23)





# INPATIENT CALIFORNIA HEALTHNET COMMERCIAL PRIOR AUTHORIZATION

Complete and Fax to: 1-844-694-9165

**Standard requests -** Determination within 5 business days of receiving all necessary information.

**Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

HMO

POS

PPO

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

**\*Indicates Required Field**

Last Name, First

\*Date of Birth

**MEMBER INFORMATION**

\*Member ID

(MMDDYYYY)

**REQUESTING PROVIDER INFORMATION** Requesting Provider Contact Name

\*Requesting NPI

\*Requesting TIN

Phone

Requesting Provider Address

\*Fax

City, State, Zip

**SERVICING PROVIDER / FACILITY INFORMATION**

Same as Requesting Provider

Servicing Provider Contact Name

\*Servicing NPI

\*Servicing TIN

Phone

**Servicing Provider/Facility Name Address**

Fax

City, State, Zip

**AUTHORIZATION REQUEST**

\*Primary Procedure Code

Additional Procedure Code

\*Start Date OR Admission Date

\*Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

Additional Procedure Code

Additional Procedure Code

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

Additional Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

**\*INPATIENT SERVICE TYPE**

**Delivery**

(Enter the Service type number in the boxes)

- 779 C-Section Delivery
- 720 Vaginal Delivery

**Inpatient Rehab**

- 427 Rehab

**Transplant**

- 992 Transplant

**Miscellaneous**

- 121 Long Term Acute Care
- 970 Medical
- 414 Premature/False Labor
- 402 Skilled Nursing Facility
- 411 Surgical
- 490 Boarder Baby
- 300 Neonate

**Miscellaneous**

- 121 Hospice Inpatient
- 492 Sub Acute

**Behavioral Health**

- 528 BH Chemical Substance Abuse
- 529 BH Psychiatric Admission

**ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.**

**COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

**Confidentiality:** The information contained in this transmission is confidential and maybe protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 02242021  
XD-PAF-1653





# No-cost Interpreter Services

## USE TO HELP PROVIDE CARE FOR HEALTH NET\* MEMBERS

No-cost interpreter services are available 24 hours a day, seven days a week.

Phone interpreters are available in over 150 languages for immediate needs.

Request in-person or video interpreters a minimum of five business days before the appointment during regular business hours. Allow 10 business days for sign language interpreter requests.



Phone interpreters in over 150 languages!

Ask for no-cost interpreter services to help you effectively communicate with your Health Net patients.

### When asking for an interpreter, all you need are:



The member's Health Net identification (ID) number



The appointment date, time and place



Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

To request interpreter services for members, contact the Provider Services Center at:

| Line of business  | Phone number                               | Hours of availability  |
|---|--|--|
| Large Employer Group  | 800-641-7761                               | Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see below for after hours)            |
| Small Employer Group (off exchange)   | 800-361-3366                               |  |
| Small Employer Group (on exchange)  | 888-926-5133                               |  |
| Individual & Family Plans (off exchange)  | 877-857-0701                               | Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see below for after hours)            |
| Individual & Family Plans (on exchange)   | 888-926-2164                               |  |
| After-hours language assistance line for Commercial (HMO, PPO, EPO, POS) line of business | 800-546-4570                               | Monday through Friday, 5 p.m. to 8 a.m., Pacific time; weekends and holidays                 |
| Medi-Cal  | 800-675-6110                               | Monday through Friday, 8 a.m. to 6 p.m., Pacific time. For after-hours select member option. |
| Cal MediConnect   | <b>Los Angeles County:</b><br>855-464-3571 | Monday through Friday from 8 a.m. to 5 p.m., Pacific time (see below for after hours)        |
|   | <b>San Diego County:</b><br>855-464-3572   |  |
| After-hours language assistance line for Cal MediConnect                                  | 800-546-4570                               | Monday through Friday from 5 p.m. to 8 a.m., weekends and holidays                           |

**For office use only. Do NOT post in a patient area.**

**Phone numbers listed here are for provider use only. Members may contact the number listed on the back of their ID card for member services.**

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# Access interpretation services 24/7 at no cost.

## This chart includes languages commonly spoken in your community; additional languages are available.

**English**

Do you speak [language]? We will provide an interpreter at no personal cost to you.

**Amharic (አማርኛ)**

እማራኛ ይናገሩሉ? እርሶ በግልጽ ምንም ወጪ ሳያውቁ እስተርጓሚ እናቀርባለን።

**(اللغة العربية) Arabic**

هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

**Armenian (հայերեն)**

Դուք հայերեն են խոսում: Մենք քեզ անվճար թարգմանիչ կսորհանք:

**Bengali (বাংলা)**

আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

**Burmese (မြန်မာ)**

သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

**Cambodian (ភាសាខ្មែរ)**

តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

**Cantonese (粵語)**

您講粵語嗎？我們將免費為您提供翻譯。

**(فارسی) Farsi**

فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

**French (Français)**

Vous parlez français ? Nous vous fournirons gratuitement un interprète.

**Greek (Ελληνικά)**

Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

**Hindi (हिन्दी)**

क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

**Hmong (Hmoob)**

Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

**Japanese (日本語)**

日本語を話せますか？ 通訳が必要な場合、こちらで無料で手配させていただきます。

**Korean (한국어)**

한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

**Lao (ພາສາລາວ)**

ທ່ານເວົ້າພາສາລາວ? ພວກເຮົາຈະຈັດງານມາແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

**Mandarin (中文)**

您講中文嗎？我們將免費為您提供翻譯。

**Mixteco**

¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

**Navajo (Diné bizaad)**

Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

**Portuguese (Português)**

Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

**Punjabi (ਪੰਜਾਬੀ)**

ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਬਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

**Russian (Русский)**

Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

**Spanish (Español)**

¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

**Tagalog**

Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

**Thai (ภาษาไทย)**

คุณพูดภาษาไทยใช่หรือไม่ เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

**Vietnamese (Tiếng Việt)**

Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

**American Sign Language (ASL)**



Please call Provider Services using the number on the member's ID card or contact 800-929-9224.

For office use only. Do NOT post in a patient area.



# ADULT HEALTH MAINTENANCE CHECKLIST

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: Male Female MR# \_\_\_\_\_  
 Immunizations current: Yes No TB Risk: Yes No  
 (See Immunization list below) (Every Periodic Physical Examination)  
 Advanced Directive discussed: Yes No Date Discussed: \_\_\_\_\_

| Examination & Tests   | Age Range  | Frequency   | DATE DONE                       | DATE DONE | DATE DONE |
|---|--|---|---------------------------------|-----------|-----------|
| INITIAL HEALTH ASSESSMENT                                     | 18 yrs. and older  | Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.                      |                                 |           |           |
| IHEBA/"Staying Healthy"                                       | 18 yrs and Older   | Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years. | Record on Staying Healthy Form. |           |           |
| Check-Up Visit  | 18 yrs. and older  | Every 1-3 years   |                                 |           |           |
|   | Age > 65   | Annually  |                                 |           |           |
| Cholesterol   | Male, 35 yrs. and older  | Every 5 years   |                                 |           |           |
|   | Female, 45 yrs. and older  | Every 5 years   |                                 |           |           |
| Diabetes Mellitus Screening                                   | As risk factors indicate   | PRN   |                                 |           |           |
| Urinalysis  | 65 yrs. and older  | PRN   |                                 |           |           |
| Breast Exam   | Age > 40 yrs.  | Annually  |                                 |           |           |
| Mammography   | 50-74 yrs.   | Every 2 years   |                                 |           |           |
| Pelvic Exam   | 19-39 yrs.   | Every 1-3 yrs.  |                                 |           |           |
|   | 40 and older   | Annually  |                                 |           |           |
| Pap Smear   | Onset of sexual activity or 21-65 yrs.   | Every 1 to 3 yrs.<br>At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.                  |                                 |           |           |
| Chlamydia   | < age 25, all sexually active non-pregnant women<br>> age 25, as risk factors indicate |   |                                 |           |           |
| Bone Density  | 65 yrs. and older  | At least once   |                                 |           |           |
| Vitamin D Deficiency  | 65 yrs. and older  | At clinician's discretion   |                                 |           |           |
| TSH Screening   | 40 yrs. and older  | Every 5 years   |                                 |           |           |
| Fecal Occult Blood  | 50-75 yrs., then at clinician's discretion   | Annually  |                                 |           |           |
| Sigmoidoscopy   | 50 and older   | 3-5 yrs.  |                                 |           |           |
|   | High Risk  | PRN   |                                 |           |           |
| Colonoscopy   | 50 and older   | Every 10 years  |                                 |           |           |
| Prostate Exam   | Physician discretion and as clinically indicated                                       | PRN   |                                 |           |           |
| PSA   | 50 and older or as clinically indicated  | PRN   |                                 |           |           |
| <b>Adult Immunizations</b>                                    |  |   |                                 |           |           |
| Tetanus-Diphtheria-Pertussis(Tdap)<br>Tetanus-Diphtheria (Td) | 18 yrs. and older  | 1 dose only   |                                 |           |           |
|   | 18 yrs. and older  | Every 10 yrs.   |                                 |           |           |
| HPV   | Females, 18-26 yrs. (HPV2 or HPV4)<br>Males, 18-26 yrs (HPV 4)                         | 3 doses   |                                 |           |           |
| Varicella   | 18 yrs. and older  | 2 doses if no evidence of immunity  |                                 |           |           |
| Zoster  | 60 yrs. and older  | 1 dose  |                                 |           |           |
| MMR   | Born 1957 or after<br>Born before 1957   | 1-2 doses unless immunity documented<br>Considered immune, unless documentation of immunity required  |                                 |           |           |
| Influenza   | 18 yrs. and older  | Annually  |                                 |           |           |
| Pneumococcal  | 18 yrs. and older  | 1-2 doses, when clinically indicated  |                                 |           |           |
| Hepatitis A   | 18 yrs. and older  | 2 doses   |                                 |           |           |
| Hepatitis B   | 18 yrs. and older  | 3 doses   |                                 |           |           |
| Meningococcal   | 18 yrs. and older  | 1 dose, 2 <sup>nd</sup> dose if high risk   |                                 |           |           |







**LAST NAME:**

**FIRST NAME:**

**MRN#**

**PLACE OF SCREENING:**

**CIRCLE ONE:** ANSI - # \_\_\_\_ ISO - # \_\_\_\_

**AUDIOMETER:**

**SCORING:** Child responds at 25 dB:  Child does not respond at 25 dB:

**DATE OF LAST CALIBRATION:**

**AGE:**

1st Screen RIGHT 1000 2000 3000 4000  
Date: \_\_\_\_\_ Ear

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

LEFT 1000 2000 3000 4000  
Ear

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

2nd Screen 1000 2000 3000 4000  
Date: \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

1000 2000 3000 4000

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Vision Test  
Date: \_\_\_\_\_

|                 | Right Eye | Left Eye |
|-----------------|-----------|----------|
| Without Glasses | 20/       | 20/      |
| With Glasses    | 20/       | 20/      |

Comments: \_\_\_\_\_  
Referred To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature & Title of Person Performing Test**

**DATE OF LAST CALIBRATION:**

**AGE:**

1st Screen RIGHT 1000 2000 3000 4000  
Date: \_\_\_\_\_ Ear

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

LEFT 1000 2000 3000 4000  
Ear

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

2nd Screen 1000 2000 3000 4000  
Date: \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

1000 2000 3000 4000

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Vision Test  
Date: \_\_\_\_\_

|                 | Right Eye | Left Eye |
|-----------------|-----------|----------|
| Without Glasses | 20/       | 20/      |
| With Glasses    | 20/       | 20/      |

Comments: \_\_\_\_\_  
Referred To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature & Title of Person Performing Test**

**DATE OF LAST CALIBRATION:**

**AGE:**

1st Screen RIGHT 1000 2000 3000 4000  
Date: \_\_\_\_\_ Ear

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

LEFT 1000 2000 3000 4000  
Ear

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

2nd Screen 1000 2000 3000 4000  
Date: \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

1000 2000 3000 4000

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Vision Test  
Date: \_\_\_\_\_

|                 | Right Eye | Left Eye |
|-----------------|-----------|----------|
| Without Glasses | 20/       | 20/      |
| With Glasses    | 20/       | 20/      |

Comments: \_\_\_\_\_  
Referred To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature & Title of Person Performing Test**





# HISTORIA MEDICA Y EXAMEN FISICO

MRN # \_\_\_\_\_

|                      |  |                |
|----------------------|--|----------------|
| NOMBRE:              | ESTADO CIVIL:<br><input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> V <input type="checkbox"/> D <input type="checkbox"/> SEP. | FECHA:         |
| FECHA DE NACIMIENTO: | TEL (CASA):  | TEL (TRABAJO): |
| OCUPACION/EMPLEADOR  | Nº del Seg. Soc.:  | Nº del SEGURO: |

## HISTORIA MEDICA FAMILIAR

SI ALGUN PARIENTE SANGUINEO HA TENIDO CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES, PONGA UN CIRCULO ALREDEDOR DEL NUMERO E INDIQUE QUE PARIENTE.

- |                      |                   |                         |                  |
|----------------------|-------------------|-------------------------|------------------|
| 1) ALCOHOLISMO       | 6) CANCER         | 11) ENFERMEDAD CARDIACA | 16) OSTEOPOROSIS |
| 2) ANEMIA            | 7) DIABETES       | 12) HIPERTENSION        | 17) APOPLEJIA    |
| 3) ASMA              | 8) EPILEPSIA      | 13) ENFERMEDAD RENAL    | 18) TIROIDES     |
| 4) ARTRITIS          | 9) GLAUCOMA       | 14) ENFERMEDAD MENTAL   | 19)              |
| 5) SANGRA FACILMENTE | 10) ASMA DEL HENO | 15) MIGRAÑA             | 20)              |

## INTERNACIONES EN HOSPITALES

(sin incluir embarazos)

AÑO ENFERMEDAD U OPERACION

Pasado:

Presente:

## ALERGIAS

**ANOTE TODOS LOS MEDICAMENTOS QUE TOMA AHORA:** (incluso los que se venden sin receta médica)

|          |           |                                    |   |
|----------|-----------|------------------------------------|---|
| 1) _____ | 7) _____  | <b>VACUNA (Fecha de la última)</b> | <b>PRUEBA / EXAMEN (Fecha del último)</b> |
| 2) _____ | 8) _____  | Tétano / Difteria                  | Colesterol                                |
| 3) _____ | 9) _____  | Influenza                          | Dental                                    |
| 4) _____ | 10) _____ | Neumocócica                        | Vista                                     |
| 5) _____ | 11) _____ | Hepatitis                          | Oído                                      |
| 6) _____ | 12) _____ |                                    | Rectal / Excremento                       |
|          |           |                                    | Sigmoidoscopia                            |
|          |           |                                    | Prueba cutánea de tuberculosis            |

## HISTORIA MEDICA

Marque con una palomita (☐) e indique la edad en la que tuvo cualquiera de los siguientes síntomas o enfermedades. MARQUE con una equis (X) los problemas actuales.

PROBLEMAS PRINCIPALES 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

|  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> Oído disminuido<br><input type="checkbox"/> Zumbido en el oído<br><input type="checkbox"/> Infecciones de oído - <i>frecuentes</i><br><input type="checkbox"/> Mareos<br><input type="checkbox"/> Falla de la vista <input type="checkbox"/> Dolor del ojo<br><input type="checkbox"/> Visión doble o borrosa<br><input type="checkbox"/> Infecciones del ojo - <i>frecuentes</i><br><input type="checkbox"/> Sangrado de la nariz - <i>recurrentes</i><br><input type="checkbox"/> Problema del seno<br><input type="checkbox"/> Dolores de garganta - <i>frecuentes</i><br><input type="checkbox"/> Asma del heno / Alergias<br><input type="checkbox"/> Ronquera - <i>prolongada</i><br><input type="checkbox"/> Neumonía / Pleuresía<br><input type="checkbox"/> Bronquitis / Tos crónica<br><input type="checkbox"/> Asma / Jadeo<br>Falta de aliento:<br><input type="checkbox"/> Haciendo esfuerzo<br><input type="checkbox"/> Estando acostado<br><input type="checkbox"/> Dolor del pecho<br><input type="checkbox"/> Presión sanguínea alta<br><input type="checkbox"/> Soplo cardíaco<br><input type="checkbox"/> Pulso irregular<br><input type="checkbox"/> Palpitaciones<br><input type="checkbox"/> Tobillos hinchados<br><input type="checkbox"/> Desmayos<br><input type="checkbox"/> Dolor de pierna - <i>caminando</i><br><input type="checkbox"/> Venas varicosas / Flebitis<br><input type="checkbox"/> Pérdida del apetito - <i>reciente</i><br><input type="checkbox"/> Dificultad para tragar | <input type="checkbox"/> Indigestión o acidez estomacal<br><input type="checkbox"/> Úlceras pépticas<br><input type="checkbox"/> Dolor abdominal - <i>crónico</i><br><input type="checkbox"/> Problema de vesícula biliar<br><input type="checkbox"/> Ictericia / Hepatitis<br><input type="checkbox"/> Cambio de hábitos de evacuación intestinal<br><input type="checkbox"/> Diarrea <input type="checkbox"/> Estreñimiento<br><input type="checkbox"/> Diverticulosis<br><input type="checkbox"/> Enfermedad de Crohn / Colitis<br><input type="checkbox"/> Excrementos sanguinolentos o alquitranados<br><input type="checkbox"/> Hemorroides<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Infecciones urinarias - <i>frecuentes</i><br><input type="checkbox"/> Sangre en la orina<br><input type="checkbox"/> Emisión de orina <input type="checkbox"/> Durante la noche más de dos veces<br><input type="checkbox"/> Dolorosa<br><input type="checkbox"/> Pérdida del control<br><input type="checkbox"/> Disminución de la Fuerza/Flujo<br><input type="checkbox"/> Cálculos renales<br><input type="checkbox"/> Enfermedad venérea<br><input type="checkbox"/> Derrame uretral<br><input type="checkbox"/> Fatiga crónica<br><input type="checkbox"/> Pérdida de peso - <i>reciente</i><br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Se magulla fácilmente | <input type="checkbox"/> Cancer<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dolor abdominal de tiroides<br><input type="checkbox"/> Convulsiones / Ataques epilépticos<br><input type="checkbox"/> Apoplejía<br><input type="checkbox"/> Temblor / Manos temblantes<br><input type="checkbox"/> Debilidad muscular<br><input type="checkbox"/> Adormecimiento / Sensaciones de hormigueo<br><input type="checkbox"/> Dolores de cabeza - <i>frecuentes</i><br><input type="checkbox"/> Artritis / Reumatismo<br><input type="checkbox"/> Dolor de Espalda - <i>recurrente</i><br><input type="checkbox"/> Fracturas óseas / Lesión de articulaciones<br><input type="checkbox"/> Gota<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Dolor de pie<br><input type="checkbox"/> Pies fríos y adormecidos<br><input type="checkbox"/> Sarpullido<br><input type="checkbox"/> Ronchas<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Sueño - <i>dificultad</i><br><input type="checkbox"/> Nerviosismo<br><input type="checkbox"/> Depresión<br><input type="checkbox"/> Pérdida de la memoria<br><input type="checkbox"/> Mal humor - <i>excesivo</i><br><input type="checkbox"/> Fobias | <input type="checkbox"/> Enfermedad mental<br><input type="checkbox"/> Varicela<br><input type="checkbox"/> Poliomielitis<br><input type="checkbox"/> Paperas<br><input type="checkbox"/> Sarampión<br><input type="checkbox"/> Rubéola<br><input type="checkbox"/> Fiebre reumática<br><input type="checkbox"/> Escarlatina<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> Contacto con sangre o fluidos corporales<br><input type="checkbox"/> Alcohol _____ onzas por semana<br><input type="checkbox"/> Fuma _____ cig. por día<br>Número de años _____<br><input type="checkbox"/> Café / Té<br>Nº de tazas por día _____<br><input type="checkbox"/> Directivas con adelanto | <b>MUJERES - Favor de completar</b><br>Flujo Menstrual:<br><input type="checkbox"/> Reg. <input type="checkbox"/> Irreg.<br><input type="checkbox"/> Dolor / Cólico<br>Días de flujo _____<br>Duraciones del ciclo _____<br>Fecha del último período _____<br><input type="checkbox"/> Dolor / Sangramiento durante o después del coito<br>Número de:<br>Embarazos _____<br>Abortos provocados _____<br>Abortos espontáneos _____<br>Nacimientos con vida _____<br>Método de control de la natalidad _____<br>Píldora de control de la natalidad (nombre) _____<br><input type="checkbox"/> Calores súbitos / Menopausia<br>Fecha del último examen pélvico _____<br>Fecha de la última prueba de Papanicolaou _____<br><input type="checkbox"/> Normal <input type="checkbox"/> Anormal<br>Fecha del último examen de senos _____<br>Fecha del último mamograma _____<br><input type="checkbox"/> Normal <input type="checkbox"/> Anormal |
|--|---|--|---|--|

**SINOPSIS PARA USO DE OFICINA SOLAMENTE:**

Directivas Anticipadas:  Si  No Educativo de Directivas Anticipadas:   
 Cuestionario "Mantengase Saludable" Fecha: \_\_\_\_\_

Firma: Dr./Dra. \_\_\_\_\_











**Medical / Behavioral CoManagement Referral Form**

|   |  |
|---|--|
| Date of Referral:<br>E-Mail:  | Referred by:<br>Referrer's phone #:  |
| Patient Name:<br>Patient Contact Information:<br>Patient Expecting MHN's Call:<br>Special Instructions:   | Patient ID #: <span style="float:right">DOB:</span>  |
| Current Provider / Primary Care Physician / Specialist Name:<br>Telephone #: <span style="float:right">Fax #:</span><br>Office Contact Name: <span style="float:right">Telephone #:</span>  |  |
| If Inpatient, complete the following:<br>Service Requested: <span style="float:right">Diagnosis:</span><br>Facility Name: <span style="float:right">Facility City/State:</span><br>Facility Contact Name: <span style="float:right">Telephone #:</span>   |  |
| <b>Requesting:</b><br>Outbound call to member <span style="float:right">Consultation with Referring Case Manager</span><br>Outbound call to provider/facility <span style="float:right">Other / Unknown</span><br>Psych consult on med bed/nursing home/SNF   |  |
| <p><b>Referral to MHN (Behavioral Health Triggers)</b></p> <ul style="list-style-type: none"> <li>Eating Disorder admitted to medical unit</li> <li>Catastrophic Illness requiring behavioral health support</li> <li>Behavioral health follow-up upon discharge from medical admission</li> <li>Complicated detox requiring medical admission</li> <li>Difficult placement due to behavioral health problems</li> <li>Medical admission with planned or actual transfer to psychiatric unit</li> <li>Referrals for post discharge substance abuse treatment while still at medical facility</li> <li>Pain management with substance abuse issues</li> <li>Frequent ER visits for behavioral health diagnoses or medical reason impacted by behavioral health issues</li> <li>Dementia with acute exacerbation of behavioral / psychological symptoms</li> <li>Autism Spectrum Disorders with behavioral health needs</li> <li>Member screened positive on depression screening</li> <li>Other</li> </ul> | <p><b>MHN referral to Health Net (Medical Triggers)</b></p> <ul style="list-style-type: none"> <li>Lack of an established or an ineffective treatment plan</li> <li>Over/under/inappropriate utilization of services</li> <li>Discharged/discharging from behavioral inpatient with medical needs</li> <li>Medical condition needing follow-up</li> <li>Lack of education of disease course/process</li> <li>Non-adherence to treatment/medications, missed appointments</li> <li>Compromised patient safety</li> <li>Lack of family/social support</li> <li>Lack of financial resources to meet health needs</li> <li>Exhaustion of medical benefits</li> <li>Member requesting medical Case Manager</li> <li>Autism Spectrum Disorders (OT, PT, ST requests)</li> <li>Pharmacological question</li> <li>Other</li> </ul> |
| Additional Information:   |  |

**Contact Information for Referrals to MHN**

- Email completed form to MHN at:  
[MHN.Case.Management.Referrals@healthnet.com](mailto:MHN.Case.Management.Referrals@healthnet.com)
- OR**
- For HNCA members, fax completed form to MHN at (855) 703-3268
- For HNAZ & HNOR/WA members, fax completed form to MHN at (855) 661-0077
- Urgent/Emergent requests, also call (888) 426-0030

Created by Sandra Morrison  
Manager, Healthnet Care Management 12/2013  
Rev 01/28/14 by L. Tulumello/T. Wasserman

**Contact Information for MHN Referrals to Health Net**

- For Health Net / MHN Use Only
- Email completed form to [Case Management Referrals/GRP/HNCA/HNT](mailto:Case.Management.Referrals/GRP/HNCA/HNT)
  - Urgent/Emergent Requests, also call (888) 732-2730





## ALERE LEVEL OF CARE CRITERIA

### NICU – Revenue Code 174

1. Ventilator/Intubated
2. Extracorporeal Membrane Oxygenation (ECMO) / Nitric Oxide (NO)
3. Any nasal flow delivered at > 2 lpm. For infants < 1kg, any nasal flow delivered at > 1 lpm.
4. Chest Tube
5. Exchange transfusion, dialysis
6. IV bolus or continuous drip therapy for severe physiologic/metabolic instability
7. Apnea/bradycardia > 10 day all requiring tactile stimulation or any episodes requiring Positive Pressure Ventilation (PPV)
8. Unstable vital signs requiring therapy or conditions requiring frequent Vital Signs. (Medical Director consultation required prior to assignment).

### TRANSITIONAL – Revenue Code 173

1. Isolette/Warmer for thermoregulation
2. Static ↓ oxygen requirement via nasal cannula (less than or equal to 2 lpm or hood)
3. Enteral nutrition delivered by methods other than p.o.
4. Intravenous fluids/blood transfusion
5. Initial sepsis evaluation (CBC, blood culture and treatment in an asymptomatic patient on the first day of evaluation)
6. Apnea/bradycardia not meeting criteria in NICU level of care
7. Neonatal abstinence syndrome when (NAS) score are: greater than or equal to 8 on three consecutive scores or greater than or equal to 12 on two consecutive scores. (Medical Director consult required prior to assignment)

### CONVALESCENT – Revenue Code 172

1. Phototherapy – intensive (double phototherapy or greater)
2. IV heparin meds
3. Neonatal Abstinence Syndrome when (NAS) scores are < 8
4. No Apnea/Bradycardia (greater than 48 hours since last episode, and otherwise meeting detained Level of Care I criteria.)
5. Diagnostic work-up/surveillance, otherwise stable using >1 consultant and/or diagnostic test.
6. Temperature instability
7. Advancing to full volume feeds
8. Stable with sub-optimal PO
9. Apnea countdown
10. Post hemorrhagic hydrocephalus

11. Growing preemie
12. Growing preemie who is stable except O<sub>2</sub> with feeds

**DETAINED/NORMAL – Revenue Code 171**

1. Diagnostic work-up/surveillance otherwise stable using 1 consultant or diagnostic test
2. Routine well baby care
3. Phototherapy (single source phototherapy)

Neonatal level of care determinations are subject to interpretation by the Alere Care Manager and Medical Director. The hospital representative has the right to discuss a determination with the Alere Care Manager and/or Medical Director and is provided the right to appeal levels of care assigned.



## *Nondiscrimination Notice*

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

### **Health Net:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

**Individual & Family Plan (IFP) Members On Exchange/Covered California** 1-888-926-4988 (TTY: 711)

**Individual & Family Plan (IFP) Members Off Exchange** 1-800-839-2172 (TTY: 711)

**Individual & Family Plan (IFP) Applicants** 1-877-609-8711 (TTY: 711)

**Group Plans through Health Net** 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances  
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: [Member.Discrimination.Complaints@healthnet.com](mailto:Member.Discrimination.Complaints@healthnet.com) (Members) or  
[Non-Member.Discrimination.Complaints@healthnet.com](mailto:Non-Member.Discrimination.Complaints@healthnet.com) (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at [www.dmhc.ca.gov/FileaComplaint](http://www.dmhc.ca.gov/FileaComplaint).

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at <https://www.insurance.ca.gov/01-consumers/101-help/index.cfm>.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

## Arabic

خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخدمة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخدمة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

## Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆոռնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

## Chinese

免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

## Hindi

बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

## Hmong

Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

**Japanese**

無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP) (個人・家族向けプラン) Off Exchange: 1-800-839-2172 (TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988 (TTY: 711) または Small Business 1-888-926-5133 (TTY: 711) までお電話ください。Health Netによるグループプランについては、1-800-522-0088 (TTY: 711) までお電話ください。

**Khmer**

សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

**Korean**

무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객센터 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

**Navajo**

Doo bą́ą́h ílinígóó saad bee háká ada'íiyeed. Ata' halne'ígíí da ła' ná hádídóot'íí. Naaltsoos da t'áá shí shizaad k'ehjí shichí' yídooltah nínízingo t'áá ná ákódoolníít. Ákót'éego shíká a'doowo' nínízingo Customer Contact Center hoolyéhíjí' hodíílnih ninaaltsoos nanítingo bee néého'dolzinígíí hodoonihjí' bikáá' éí doodago kojí' hólné' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojí' hólné' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojí' hólné' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojí' hólné' 1-800-522-0088 (TTY: 711).

**Persian (Farsi)**

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange) به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک (TTY:711) 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

### **Panjabi (Punjabi)**

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਐਂਡ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐਂਡ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੇਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

### **Russian**

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

### **Spanish**

Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

### **Tagalog**

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

### **Thai**

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรมาด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมาด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมาด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมาด TTY: 711)

**Vietnamese**

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)





## Offshore Subcontracting Attestation: Participating Provider

|   |                                   |
|---|-----------------------------------|
| <b>If you are a Health Net of California, Inc., Health Net Community Solutions, Inc. and/or Health Net Life Insurance Company (Health Net) participating provider (also referred to as first-tier, downstream or related entities) using offshore subcontractors, indicate your business name and tax identification (ID) number below.</b>   |                                   |
| <b>Name of participating provider (if applicable):</b>  |                                   |
| <b>Tax ID:</b>  |                                   |
| <b>If you manage multiple participating providers, list the name(s) and tax IDs for whom you are completing this attestation or attach a separate sheet.</b>  |                                   |
|   |                                   |
| <b>Enter your name, title, phone number, signature, and date that you completed this attestation.</b>   |                                   |
| <b>Name:</b>  | <b>Title:</b>                     |
| <b>Phone number:</b>  |                                   |
| <b>Signature:</b>   |                                   |
| <b>Date:</b>  |                                   |
| <b>Do you utilize offshore subcontractors?</b><br>The Centers for Medicare & Medicaid Services (CMS) defines <i>offshore subcontractor</i> as follows:<br>“The term subcontractor refers to any organization that a Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. Subcontractors include all first-tier, downstream and/or related entities. The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of ‘offshore’ include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.”<br>Health Net policy prohibits the transfer or storage of data outside the United States. | <b>Response:</b><br>Yes<br><br>No |
| <b>Do you engage in offshore subcontracting that involves processing, handling or accessing protected health information (PHI)?</b><br>If “No,” the survey is complete and you do not need to complete or submit the attestation.<br>If “Yes,” continue completing the form and submit a copy via mail or fax to:<br><br>Health Net<br>Kristina Rodriguez<br>Director, Provider Network Management Operations<br>Email: Kristina.M.Rodriguez@healthnet.com<br><br>This form must be completed in full for each new offshore subcontractor, and sent to Health Net within 20 calendar days from the date the contract is signed with the offshore subcontractor to the address or fax number provided above.   | <b>Response:</b><br>Yes<br><br>No |

## Offshore Subcontracting Attestation: Participating Provider

| <b>Part I. Offshore subcontractor information</b>                                      |  |
|--|--|
| Offshore subcontractor name:   |  |
| Offshore subcontractor country:  |  |
| Offshore subcontractor address:  |  |
| Describe offshore subcontractor functions:   |  |
| State proposed or actual effective date for offshore subcontractor (Month, day, year): |  |

| <b>Part II. Precautions for PHI</b>  |  |
|--|--|
| Describe the PHI that will be provided to the offshore subcontractor:                          |  |
| Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:    |  |
| Describe alternatives considered to avoid providing PHI and why each alternative was rejected: |  |

### Offshore Subcontracting Attestation: Participating Provider

| <b>Part III. Attestation of safeguards to protect beneficiary information in the offshore subcontract</b> |   |                                 |
|---|---|---------------------------------|
| <b>Item</b>   | <b>Attestation</b>  | <b>Response:<br/>Yes<br/>No</b> |
| <b>III.1</b>  | Offshore subcontracting arrangement has policies and procedures in place to ensure that beneficiary PHI and other personal information remain secure.   |                                 |
|   | Participating provider to provide a copy of the policies and procedures that document the process used to ensure the security of beneficiary PHI and other personal information. Copies are provided to Health Net along with this completed attestation.   |                                 |
| <b>III.2</b>  | Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with the sponsor's contract with the offshore subcontractor.  |                                 |
| <b>III.3</b>  | Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.   |                                 |
|   | Participating provider to provide a copy of the policies and procedures that document the process used for the immediate termination of the subcontract upon discovery of a significant security breach. Copies are provided to Health Net along with this completed attestation.   |                                 |
| <b>III.4</b>  | Offshore subcontracting arrangement includes all required Medicare Part C and Part D language, such as record retention requirements, compliance with all Medicare Part C and Part D requirements, etc.   |                                 |
|   | Applicable to participating providers contracting with Health Net for the Medicare Advantage line of business – Participating provider to provide a copy of the provider's agreement (proprietary information removed) with the offshore subcontractor. A copy is provided to Health Net along with this completed attestation. |                                 |

| <b>Part IV. Attestation of audit requirements to ensure protection of PHI</b> |   |                                 |
|---|---|---------------------------------|
| <b>Item</b>   | <b>Attestation</b>  | <b>Response:<br/>Yes<br/>No</b> |
| <b>IV.1</b>   | Participating provider will conduct an annual audit of the offshore subcontractor.  |                                 |
|   | Participating provider to provide a copy of the policies and procedures documenting the process used for conducting annual audits, for monitoring and tracking results, and resolving any identified deficiencies. Copies are provided to Health Net along with this completed attestation. |                                 |
| <b>IV.2</b>   | Audit results are used by the participating provider to evaluate the continuation of its relationship with the offshore subcontractor.  |                                 |
| <b>IV.3</b>   | Participating provider agrees to share offshore subcontractors' audit results with Health Net or CMS upon request.  |                                 |





# OUTPATIENT CALIFORNIA HEALTHNET COMMERCIAL AUTHORIZATION FORM

Complete and **Fax** to: 1-844-694-9165  
Transplant **Fax** to: 1-833-769-1142

HMO

Request for additional units. Existing Authorization Units

POS

**Standard requests -** Determination within 5 business days of receiving all necessary information.

PPO

**Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

\* INDICATES REQUIRED FIELD  X  URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.  
Last Name, First \*Date of Birth

## MEMBER INFORMATION

\*Member ID (MMDDYYYY)

## REQUESTING PROVIDER INFORMATION

 Requesting Provider Contact Name

\*Requesting NPI \*Requesting TIN Phone

Requesting Provider Address \*Fax

City, State, Zip

## SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider Servicing Provider Contact Name -

\*Servicing NPI \*Servicing TIN - Phone

Servicing Provider/Facility Name Address Fax

City, State, Zip

## AUTHORIZATION REQUEST

\*Primary Procedure Code Additional Procedure Code \*Start Date OR Admission Date \*Diagnosis Code

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)

Additional Procedure Code Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)

(Enter the Service type number in the boxes)

### \*OUTPATIENT SERVICE TYPE

- 412 Auditory
- 422 Biopharmacy
- 712 Cochlear Implants & Surgery
- 299 Drug Testing
- 922 Experimental and Investigational Services
- 205 Genetic Testing & Counseling
- 249 Home Health
- 390 Hospice Services
- 290 Hyperbaric Oxygen Therapy
- 395 Infertility Diagnosis or Treatment
- 211 OB Ultrasound

- 410 Observation
- 997 Office Visit/Consult
- 210 Orthotics
- 794 Outpatient Services
- 171 Outpatient Surgery
- 202 Pain Management
- 147 Prosthetics
- 428 Second Opinion
- 201 Sleep Study
- 993 Transplant Evaluation
- 209 Transplant Surgery
- 724 Transportation

### Behavioral Health

- 533 BH Applied Behavioral Analysis
- 512 BH Community Based Services
- 515 BH Electroconvulsive Therapy
- 516 BH Intensive Outpatient Therapy
- 510 BH Medical Management
- 518 BH Mental Health /Chemical Dependency Observation
- 519 BH Outpatient Therapy
- 530 BH PHP
- 520 BH Professional Fees
- 522 BH Psychiatric Evaluation
- 521 BH Psychological Testing

### DME

- 417 Rental
- 120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Rev.02242021

XD-PAF-1654





### Health Net Contracted Palliative Care Providers

| Ancillary Name                                    | Address   | Phone        | Service Type |
|---|---|--------------|--------------|
| Assisted Home Hospice – North Hills               | 10550 Sepulveda Blvd, Suite 101<br>Mission Hills, CA 91345  | 818-830-5003 | Hospice      |
| Assisted Home Hospice – Ventura                   | 4450 Westinghouse Street, Suite 103<br>Ventura, CA 93003    | 805-677-7405 | Hospice      |
| Assisted Home Hospice – Los Angeles               | 3731 Wilshire Blvd, Suite 518<br>Los Angeles, CA 90010      | 213-355-3511 | Hospice      |
| Assisted Home Hospice – Santa Barbara             | 115 E Micheltorena St, Suite 100<br>Santa Barbara, CA 93101 | 805-569-2000 | Hospice      |
| Carechoices Hospice and Palliative Services, Inc. | 20 Corporate Park, Suite 300<br>Irvine, CA 92606            | 949-777-8600 | Hospice      |
| Community Hospice, Inc.                           | 4368 Spyres Way<br>Modesto, CA 95356                        | 209-578-6300 | Hospice      |
| Hinds Hospice                                     | 2490 W Shaw Ave, Suite 101<br>Fresno, CA 93711              | 559-226-5683 | Hospice      |
| Hinds Hospice                                     | 1416 W Twain Ave Fresno, CA<br>93711                        | 559-222-0793 | Hospice      |
| Hinds Hospice                                     | 410 W Main St, Suite A Merced,<br>CA 95340                  | 209-383-3123 | Hospice      |
| Hoffman Hospice Of The Valley, Inc.               | 4325 Buena Vista Rd<br>Bakersfield, CA 93311                | 661-410-1010 | Hospice      |
| Hospice of East Bay                               | 3470 Buskirk Ave Pleasant Hill, CA<br>94523                 | 925-887-5678 | Hospice      |
| Hospice of East Bay                               | 2849 Miranda Ave<br>Alamo, CA 94507                         | 925-945-8924 | Hospice      |
| Hospice of The Foothills                          | 11270 Rough and Ready Hwy Grass<br>Valley, CA 95945         | 530-272-5739 | Hospice      |
| Libertana Home Health                             | 5805 Sepulveda Blvd, Suite 605<br>Sherman Oaks, CA 91411    | 800-750-1444 | Hospice      |
| MedZed Palliative Care – California               | 300 Corporate Pointe, Suite 465<br>Culver City, CA 90230    | 323-203-0070 | Home Health  |

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**Health Net Contracted Palliative Care Providers, continued**

| <b>Ancillary Name</b>                         | <b>Address</b>  | <b>Phone</b> | <b>Service type</b> |
|---|---|--------------|---------------------|
| Lightbridge Hospice, LLC                      | 6155 Cornerstone Ct E, Suite 220<br>San Diego, CA 92121     | 858-458-2992 | Hospice             |
| Noble Hospice Care, Inc.                      | 41305 Albrae St., Suite A<br>Fremont, CA 94538              | 510-683-9100 | Hospice             |
| Prohealth Home Care                           | 2700 Zanker Rd, Suite 180<br>San Jose, CA 95134             | 408-451-9055 | Home Health         |
| Prohealth Home Care –<br>Sacramento           | 1375 Exposition Blvd, Suite 250A&B<br>Sacramento, CA 95815  | 877-667-8770 | Home Health         |
| Prohealth Home Care, Inc.                     | 1776 W. March Ln, Suite 400A&B<br>Stockton, CA 95207        | 877-311-5001 | Home Health         |
| Prohealth Home Care –<br>Walnut Creek         | 2125 Oak Grove Rd, Suite 124A&B<br>Walnut Creek, CA 94598   | 925-933-2565 | Home Health         |
| Providence TrinityCare Hospice                | 17315 Studebaker Rd, Suite 101<br>Cerritos, CA 90703        | 562-402-3336 | Hospice             |
| ResolutionCare, Pc                            | 517 3rd St, Suite 2<br>Eureka, CA 95501                     | 707-442-5683 | Hospice             |
| Roze Room Hospice                             | 5000 Overland Ave, Suite 101<br>Culver City, CA 90230       | 310-202-7693 | Hospice             |
| Roze Room Hospice                             | 2700 E Foothill Blvd, Suite 200<br>Pasadena, CA 91107       | 626-446-7673 | Hospice             |
| Roze Room Hospice                             | 4510 E Pacific Coast Hwy, Suite 320<br>Long Beach, CA 90804 | 562-597-8273 | Hospice             |
| Roze Room Hospice                             | 18107 Sherman Way, Suite 100<br>Reseda, CA 91335            | 818-783-1002 | Hospice             |
| Roze Room Hospice                             | 5675 Ralston St., Suite C<br>Ventura, CA 93003              | 805-654-0191 | Hospice             |
| Snowline Hospice of El Dorado<br>County, Inc. | 6520 Pleasant Valley Rd<br>Diamond Springs, CA 95619        | 530-621-7820 | Hospice             |
| The Elizabeth Hospice                         | 500 La Terraza Blvd, Suite 130<br>Escondido, CA 92025       | 760-737-2050 | Hospice             |





**Request for Necessary Medical Information for Prior Authorization**

**URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY**

**WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION**

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

**Patient Information**

|               |                 |
|---------------|-----------------|
| Patient Name  | Subscriber ID # |
| Date of Birth | Today's Date    |

**Provider Information**

|                           |                               |
|---------------------------|-------------------------------|
| Facility Name             | Facility Tax ID #             |
| Telephone #               | Fax                           |
| Requesting Physician Name | ICD-9 Code                    |
| Facility Contact Person   | Telephone # of Contact Person |

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

**Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.**

| <b>Occupational and Physical Therapy</b>   |
|--|
| 1. What is the patient's diagnosis (describe in detail)?   |
| 2. What is the patient's dominant hand? Right or left?   |
| 3. What was the exact date of surgery and the exact type of surgery?   |
| 4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31? |
| 5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?          |
| 6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?         |

|  |       |
|--|-------|
| 7. What are the exact physical or occupational therapy modalities being utilized at this time?       |       |
| 8. What was the patient's range of motion at the onset of physical or occupational therapy?          |       |
| 9. What was the patient's range of motion four weeks ago?  | Date: |
| 10. What was the patient's range of motion two weeks ago?  | Date: |
| 11. What is the patient's range of motion now?   | Date: |
| 12. What exercises has the patient been performing?  |       |
| 13. How many repetitions and at what weight was the patient able to perform at the start of therapy? | Date: |
| 14. How many repetitions and at what weight was the patient able to perform four weeks ago?          | Date: |
| 15. How many repetitions and at what weight was the patient able to perform two weeks ago?           | Date: |
| 16. How many repetitions and at what weight is the patient able to perform now?                      | Date: |
| 17. What is the goal range of motion and goal strength?  |       |
| 18. When do you anticipate the member will reach this goal?  |       |
| 19. When do you anticipate the member will be transitioned to a home exercise program?               |       |

| <b>Speech Therapy</b>  |  |
|--|--|
| 1. Please provide the plan of care addressing the following: <ul style="list-style-type: none"> <li>a. The date of onset or exacerbation of the disorder/diagnosis:</li> <li>b. Specific statements of long-term and short-term goals:</li> <li>c. Quantitative objectives measuring current age-adjusted level of functioning:</li> <li>d. A reasonable estimate of when the goals will be reached:</li> <li>e. The specific treatment techniques or exercises to be used in treatment:</li> <li>f. The frequency and duration of treatment:</li> </ul> |  |
| 2. How many speech therapy sessions have been provided this calendar year prior to this request?   |  |
| 3. Is there progress or improvement with the therapy?  |  |

**Please attach any additional documentation supporting this request to the back of this form.**

Fax the requested information to:

Health Net Prior Authorization Department  
**(800) 672-2135**



# Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

**Do not photocopy this form. The information contained is confidential and peer-review protected.  
Complete all fields and forward immediately to Health Net\* via secure fax: (877) 808-7024.**



## PURPOSE

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

## IMPORTANT

The PQI Referral Form is a confidential document used by the Health Net Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to Health Net enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner.

Refer issues identified as *member appeals* or *member grievances* to Health Net's Member Appeals and Grievances Department for appropriate case handling and resolution.

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

## REFERRAL CONTENT

1. All the fields on the PQI form are **required** fields.
2. Use the fillable PDF form to complete the PQI referral. Do not fax a handwritten PQI referral form. Handwritten PQI forms will be returned to originator for proper re-submission.
3. All sections of the PQI referral must be completed.
4. The form should be completed as follows:
  - a) Referral source – Include referral date, first and last name of the associate completing the referral, contact information (telephone number, fax number) and the name of the associate who identified the PQI. If same as the referred by, enter *same as referred by* in this section.
  - b) Member demographics – Include member first and last name, member ID, member's current primary care physician (PCP) and the associated participating physician group (PPG).
  - c) PQI Event Dates / Filed Against Details – Include date of event, first and last name of practitioner that PQI is filed against (if same as PCP, re-enter PCP and PPG name here) and practitioner's office location. If hospital, please include name of hospital and location. Provide an admission date. Indicate the type of PQI using the check box items provided on the PQI referral. In the description of event field, describe event(s) chronologically, including dates, provider or practitioner names, specify any equipment or medication involved, quote relevant statements made by the provider or others and provide a complete explanation describing the potential deviation in the standard of care.
5. Complete and submit this report directly via secure fax at (877) 808-7024 within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
6. Incomplete referral forms are returned to the Health Net associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

# Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)



**Do not photocopy this form. The information contained is confidential and peer-review protected.**  
**Complete all fields and forward immediately to Health Net\* via secure fax: (877) 808-7024.**

| REFERRAL SOURCE                         | MEMBER DEMOGRAPHICS                                |
|---|--|
| Referral date: _____                    | Member name (Last, First, MI): _____               |
| Referred by (First, Last Name): _____   | ID#: _____   |
| Identified by (First, Last Name): _____ | Current Primary care physician (PCP): _____        |
| Telephone number: _____                 | Current participating physician group (PPG): _____ |
| Fax number: _____                       |  |

| PQI EVENT DATES                              | FILED AGAINST DETAILS:   |
|--|--|
| Date(s) of PQI event: _____                  | Provider/Practitioner Name: (First, Last or name of facility): _____ |
| Admission date: _____                        |  |
| Prior admission dates (if applicable): _____ | Associated Provider/Practitioner PPG: _____                          |
| _____  | Provider/Practitioner Location: _____                                |
| _____  | Provider/Practitioner NPI#: _____                                    |

**HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS (Bolded text indicates HAC/HCAC, OPPC OR SRAE)**

|   |   |
|---|---|
| <p><b>Surgical events:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Surgery on wrong body part</b></li><li><input type="checkbox"/> <b>Surgery on wrong patient</b></li><li><input type="checkbox"/> <b>Wrong surgical procedures on a patient</b></li><li><input type="checkbox"/> <b>Foreign object retained after surgery</b></li><li><input type="checkbox"/> Anesthesia adverse event</li><li><input type="checkbox"/> <b>Surgery with post-operative/intra-operative death in a normal healthy patient</b></li><li><input type="checkbox"/> Acute MI or CVA within 48 hours after elective surgery</li><li><input type="checkbox"/> Cardiac or respiratory arrest in the operating room (OR)</li><li><input type="checkbox"/> Unplanned return to OR, unplanned removal, injury or repair of an organ</li><li><input type="checkbox"/> Other (explain) _____</li></ul> <p><b>Surgical site/post-operative infections:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Mediastinitis after coronary artery bypass graft (CABG)</b></li><li><input type="checkbox"/> <b>Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)</b></li><li><input type="checkbox"/> <b>Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip</b></li><li><input type="checkbox"/> Other (explain) _____</li></ul> | <p><b>Patient death/disability:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility</li><li><input type="checkbox"/> Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics</li><li><input type="checkbox"/> Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended</li><li><input type="checkbox"/> Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)</li><li><input type="checkbox"/> Unexpected death (Please explain) _____</li></ul> <p><b>Patient issue:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Member leaves against medical advice (AMA) when there is a potential for serious adverse event(s)</li><li><input type="checkbox"/> Patient suicide attempt or serious injury to self while in treatment</li><li><input type="checkbox"/> Other (explain) _____</li></ul> |
|---|---|

# Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)



**Do not photocopy this form. The information contained is confidential and peer-review protected. Complete all fields and forward immediately to Health Net\* via secure fax: (877) 808-7024.**

**HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS (Bolded text indicates HAC/HCAC, OPPC OR SRAE)**

**Hospital-acquired (nosocomial) infections:**

- Catheter-associated urinary tract infection (UTI)**
- Vascular catheter-associated Infection**
- Other (explain) \_\_\_\_\_

**Deep vein thrombosis or pulmonary embolism following orthopedic procedures:**

- Total knee replacement**
- Total hip replacement**
- Other (explain) \_\_\_\_\_

**Falls (with trauma):**

- Fractures**
- Dislocations**
- Intracranial injuries**
- Other (explain) \_\_\_\_\_

**Injury:**

- Crushing injuries**
- Burns**
- Electric shock**
- Other (explain) \_\_\_\_\_

**Manifestations of poor glycemic control:**

- Diabetic ketoacidosis**
- Nonketotic hyperosmolar coma**
- Hypoglycemic coma**
- Secondary diabetes with ketoacidosis**
- Secondary diabetes with hyperosmolarity**

**Obstetrics:**

- Nonmedically indicated (elective) delivery less than 39 weeks gestational age
- Newborn Apgar < 4 at 1 minute or < 6 at 5 minutes

**Admission/readmission/discharge:**

- Unexpected / unanticipated readmission within 30 days to acute level of care with same or similar diagnosis or as a complication of the previous admission
- Unplanned admission following diagnostic test or outpatient procedure
- Neurological deficit present at discharge not present on admit
- Delay in transfer/treatment or discharge - which results in a poor outcome to the member or additional costs to the plan
- Delayed diagnosis or missed diagnosis - resulting in adverse member outcome or extended hospital stay
- Infant discharged to the wrong person**

**Outpatient/ambulatory care:**

- Breach of member confidentiality or ethics concern/violation
- Abnormal diagnostic study not followed up appropriately where the potential for adverse outcome exists
- Inattention to or lack of appropriate follow-up of consultant's major recommendations without appropriate rationale
- Practitioner's failure to follow-up on any member's significant complaint or physical finding within a reasonable period of time
- Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
- Hospitalization resulting from inappropriate drug therapy

**Other:**

- Pressure ulcer stages III & IV occurring after hospital admission**
- Air embolism**
- Blood transfusion incompatibility**
- Any substandard care with the potential for harm to the member (please explain fully) \_\_\_\_\_
- Member refused to file a grievance
- Grievance withdrawal
- Other (select only when no other selection is applicable and explain fully) \_\_\_\_\_



# Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

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Complete all fields and forward immediately to Health Net\* via secure fax: (877) 808-7024.**



**Description of event:**

**Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons  
(please provide complete and detailed summary - must be typed, not handwritten):**

\*Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.



## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: \_\_\_\_\_ Plan/Medical Group Phone#: (\_\_\_\_\_) \_\_\_\_\_  
 Plan/Medical Group Fax#: (\_\_\_\_\_) \_\_\_\_\_ Non-Urgent  Exigent Circumstances

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

### Patient Information

|  |  |   |       |   |               |           |
|--|--|---|-------|---|---------------|-----------|
| First Name:  |  | Last Name:  |       | MI:                                     | Phone Number: |           |
| Address:   |  |   | City: |   | State:        | Zip Code: |
| Date of Birth:                                       | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Circle unit of measure<br>Height (in/cm): _____ Weight (lb/kg): _____ |       | Allergies:                              |               |           |
| Patient's Authorized Representative (if applicable): |  |   |       | Authorized Representative Phone Number: |               |           |

### Insurance Information

|                           |  |                    |  |
|---------------------------|--|--------------------|--|
| Primary Insurance Name:   |  | Patient ID Number: |  |
| Secondary Insurance Name: |  | Patient ID Number: |  |

### Prescriber Information

|   |  |            |                                       |            |                  |
|---|--|------------|---------------------------------------|------------|------------------|
| First Name:                               |  | Last Name: |                                       | Specialty: |                  |
| Address:                                  |  |            | City:                                 |            | State: Zip Code: |
| Requestor (if different than prescriber): |  |            | Office Contact Person:                |            |                  |
| NPI Number (individual):                  |  |            | Phone Number:                         |            |                  |
| DEA Number (if required):                 |  |            | Fax Number (in HIPAA compliant area): |            |                  |
| Email Address:                            |  |            |                                       |            |                  |

### Medication / Medical and Dispensing Information

|  |            |   |           |
|--|------------|---|-----------|
| Medication Name:   |            |   |           |
| <input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request<br>If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____ |            |   |           |
| How did the patient receive the medication?  |            |   |           |
| <input type="checkbox"/> Paid under Insurance Name: _____  |            | Prior Auth Number (if known): _____   |           |
| <input type="checkbox"/> Other (explain): _____  |            |   |           |
| Dose/Strength:   | Frequency: | Length of Therapy/#Refills:   | Quantity: |
| Administration:  |            |   |           |
| <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____   |            |   |           |
| Administration Location:   |            | <input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care<br><input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____<br><input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care |           |

## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

|               |      |
|---------------|------|
| Patient Name: | ID#: |
|---------------|------|

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

|   |
|---|
| <b>1. Has the patient tried any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO |
|---|

| Medication/Therapy<br>(Specify Drug Name and Dosage) | Duration of Therapy<br>(Specify Dates) | Response/Reason for Failure/Allergy |
|--|--|-------------------------------------|
|  |  |                                     |

|                           |                |
|---------------------------|----------------|
| <b>2. List Diagnoses:</b> | <b>ICD-10:</b> |
|---------------------------|----------------|

|  |  |
|--|--|
|  |  |
|--|--|

|  |
|--|
| <b>3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.</b> |
|--|

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

Attachments

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**Plan/Insurer Use Only:**      Date/Time Request Received by Plan/Insurer: \_\_\_\_\_      Date/Time of Decision \_\_\_\_\_

Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

Approved     Denied    Comments/Information Requested: \_\_\_\_\_



# BE INFORMED

If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment pursuant to Section 1704.7 of the California Health & Safety Code.

The information about methods of treatment was developed by the State Department of Health Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures.

# INFÓRMESE

Si es usted un paciente que está recibiendo tratamiento contra cualquier forma de cáncer de próstata, o en la etapa previa a una biopsia por cáncer prostático, su médico o cirujano está urgido dar a usted un sumario escrito de los métodos alternativos de tratamiento disponibles considerados eficaces. Esto es en cumplimiento con la Sección 1704.7 del Código de Salud y Seguridad del Estado de California.

La información sobre los métodos de tratamiento fueron desarrollados por los Servicios de Salud del Estado de California para informar a los pacientes sobre las ventajas y desventajas, riesgos y descripciones de los procedimientos.

# 通知

如果你是前列腺癌患者或如要进行前列腺癌的切片測驗，按照加省衛生安全規則第 1704.7 部份，你的醫生必要向你提供一份有關各種有效治療的報告書。

各種治療的資料是由國家衛生服務局所提供，來使病人知道各種不同治療的好處、壞處、危險和治療的程序。



# Provider Dispute Resolution Request

## Commercial and Medi-Cal

### INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (\*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

**Health Net Commercial Provider Appeals Unit**  
**PO Box 9040 Farmington, MO 63640-9040**  
**Commercial Provider Services Center 1-800-641-7761**

**Health Net Medi-Cal Provider Appeals Unit**  
**PO Box 989881 West Sacramento, CA 95798-9881**  
**Medi-Cal Provider Services Center 1-800-675-6110**

|   |                               |  |
|---|-------------------------------|--|
| *Provider name:   |                               | *Provider tax ID #:  |
| *Provider address   |                               | Contracted? <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| <b>Provider type:</b> <input type="checkbox"/> Physician <input type="checkbox"/> Mental health <input type="checkbox"/> Hospital <input type="checkbox"/> ASC/outpatient services <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab<br><input type="checkbox"/> Home health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other professional (please specify type of other) _____ |                               |  |
| <b>*Claim information:</b> <input type="checkbox"/> Single <input type="checkbox"/> Multiple <b>"LIKE"</b> claims (complete attached spreadsheet) Number of claims _____  |                               |  |
| *Patient name:  |                               | Date of birth:   |
| *Health Plan ID number:   | *Subscriber ID/CIN number:    | *Original claim ID/Submission ID number:<br>(If multiple claims, use attached spreadsheet) |
| *Service from/to date:  | Original claim amount billed: | Original claim amount paid:  |
| <b>Dispute type:</b> <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of medical necessity/utilization management decision <input type="checkbox"/> Contract dispute<br><input type="checkbox"/> Seeking resolution of a billing determination <input type="checkbox"/> Disputing a request for reimbursement of overpayment <input type="checkbox"/> Other   |                               |  |
| <b>*Description of dispute:</b> Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)   |                               |  |
| <b>*Expected outcome:</b> (Please provide by claim if multiple.)  |                               |  |

|                             |               |                            |
|-----------------------------|---------------|----------------------------|
|                             |               | ( )                        |
| Contact name (please print) | Title         | Area code and phone number |
|                             |               | ( )                        |
| Signature and date          | Email address | Area code and fax number   |

**Check here if additional information is attached:**  
 (Please do not staple information.)

Page \_\_\_ of \_\_\_

**For Health Plan Use Only**  
**Case#** \_\_\_\_\_  
**Provider#** \_\_\_\_\_



**Commercial and Medi-Cal Provider Dispute Resolution Request, *continued***

**INSTRUCTIONS (for use with multiple like claims only)**

- Please complete the form fields below. Fields with an asterisk (\*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
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- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

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**PO Box 9040 Farmington, MO 63640-9040**  
**Commercial Provider Services Center 1-800-641-7761**

**Health Net Medi-Cal Provider Appeals Unit**  
**PO Box 989881 West Sacramento, CA 95798-9881**  
**Medi-Cal Provider Services Center 1-800-675-6110**

| Number | *Patient name |       | Date of birth | *Subscriber ID/CIN number | *Original claim ID/Submission ID number | *Service from/to date | Original claim amount billed | Original claim amount paid | *Expected outcome |
|--------|---------------|-------|---------------|---------------------------|---|-----------------------|------------------------------|----------------------------|-------------------|
|        | Last          | First |               |                           |   |                       |                              |                            |                   |
| 1      |               |       |               |                           |   |                       |                              |                            |                   |
| 2      |               |       |               |                           |   |                       |                              |                            |                   |
| 3      |               |       |               |                           |   |                       |                              |                            |                   |
| 4      |               |       |               |                           |   |                       |                              |                            |                   |
| 5      |               |       |               |                           |   |                       |                              |                            |                   |
| 6      |               |       |               |                           |   |                       |                              |                            |                   |
| 7      |               |       |               |                           |   |                       |                              |                            |                   |
| 8      |               |       |               |                           |   |                       |                              |                            |                   |
| 9      |               |       |               |                           |   |                       |                              |                            |                   |
| 10     |               |       |               |                           |   |                       |                              |                            |                   |
| 11     |               |       |               |                           |   |                       |                              |                            |                   |
| 12     |               |       |               |                           |   |                       |                              |                            |                   |

Check here if additional information is attached:  
 (Please do not staple information.)

|  |
|--|
| <p><b>For Health Plan Use Only</b><br/>                 Case# _____<br/>                 Provider# _____</p> |
|--|

Page \_\_\_ of \_\_\_





**IFP Provider Dispute Resolution Request, *continued***

**INSTRUCTIONS (for use with multiple like claims only)**

- Please complete the form fields below. Fields with an asterisk (\*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-641-7761.
- Mail the completed form to the following address.

**IFP Provider Disputes and Appeals Unit**  
**PO Box 9040**  
**Farmington, MO 63640-9040**

| Number | *Patient name |       | Date of birth | *Subscriber ID/CIN number | *Original claim ID/Submission ID number | *Service from/to date | Original claim amount billed | Original claim amount paid | *Expected outcome |
|--------|---------------|-------|---------------|---------------------------|---|-----------------------|------------------------------|----------------------------|-------------------|
|        | Last          | First |               |                           |   |                       |                              |                            |                   |
| 1      |               |       |               |                           |   |                       |                              |                            |                   |
| 2      |               |       |               |                           |   |                       |                              |                            |                   |
| 3      |               |       |               |                           |   |                       |                              |                            |                   |
| 4      |               |       |               |                           |   |                       |                              |                            |                   |
| 5      |               |       |               |                           |   |                       |                              |                            |                   |
| 6      |               |       |               |                           |   |                       |                              |                            |                   |
| 7      |               |       |               |                           |   |                       |                              |                            |                   |
| 8      |               |       |               |                           |   |                       |                              |                            |                   |
| 9      |               |       |               |                           |   |                       |                              |                            |                   |
| 10     |               |       |               |                           |   |                       |                              |                            |                   |
| 11     |               |       |               |                           |   |                       |                              |                            |                   |
| 12     |               |       |               |                           |   |                       |                              |                            |                   |

Check here if additional information is attached:  
(Please do not staple information.)

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|--|
| <p><b>For Health Plan Use Only</b><br/> Case# _____<br/> Provider# _____</p> |
|--|



## Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) Quick Reference Guide

eviCore healthcare administers the utilization management program for all outpatient MRI/MRA, CT/CTA, PET imaging studies, nuclear cardiac imaging procedures, including single photon emission computed tomography (SPECT), and sleep studies for all HMO, CommunityCare HMO, EPO, PPO, and Medicare Advantage (MA) Direct Network/Fee-for-Service members.

### **Imaging procedures performed during an inpatient admission or emergency room visit are NOT included in this program.**

All of the outpatient imaging services listed above will be evaluated based on the applicable terms of the health benefit plan (including, but not limited to, medical necessity) and require prior authorization by eviCore healthcare. Services will be authorized for covered imaging studies performed at a facility within the Health Net network.

eviCore healthcare will respond to requests for prior authorization within two business days once complete clinical information is received.

### **Prior Authorization Process**

There are three ways to request prior authorization for an imaging procedure from eviCore healthcare:

#### **1. Internet**

Complete the Internet-based submission form by logging on to the secure Web site at **www.evicore.com**.

#### **2. Telephone**

Contact eviCore healthcare toll-free, 5:00 a.m. to 6:00 p.m. PST, Monday through Friday at **(888) 693-3211** and give all pertinent clinical information over the telephone. Outside of these normal business hours, you may call eviCore healthcare and leave a voice mail for a return call the next business day. When calling eviCore healthcare with a request for prior authorization, please have the following information available:

- Member demographic information, including Health Net member ID and date of birth
- Current diagnosis and clinical information, including treatment history, treatment plan and medications
- Member's chart and previous imaging study results

#### **3. Fax**

Complete the demographics box at the top of the fax form and **include the office notes/previous imaging reports** for the member and fax your request to eviCore healthcare at (888) 693-3210.

### **Coverage Authorizations**

Your request for prior authorization will be processed **within two business days** after the receipt of all necessary information. Once coverage is approved, an authorization number will be faxed to the ordering physician and requested facility, and mailed to the member. Please note: eviCore healthcare will specifically approve both the facility to perform the imaging study and the CPT code or codes for the diagnostic imaging.

### **Coverage Denials**

If a request for prior authorization is denied, an eviCore healthcare representative will call the ordering physician's office and verbally communicate the denial determination and the rationale for the denial. The ordering physician may request a reconsideration of the denial decision by either faxing additional information or discussing the denial determination with the eviCore healthcare physician reviewer. Written notification of the final determination will be faxed to the requesting physician and mailed to the member. The written notification will include information about the member appeal rights.

### **Peer Review**

Referring physicians or radiologists may request a peer review discussion of a denial decision with one of MedSolutions' physician reviewers. To request a peer review, call eviCore healthcare at (888) 693-3211 during normal business hours of 5:00 a.m. to 6:00 p.m. PST, Monday through Friday.

### **Expedited Requests**

If the referring physician believes a medical emergency is occurring, prior authorization is not required for diagnostic imaging studies performed on an outpatient, emergent basis. eviCore healthcare physician reviewers will retrospectively review the request and the clinical documentation supporting the nature of the medical emergency.

**MEDICALLY URGENT:** For those situations where advanced imaging is required on the same day due to a medically urgent condition, **call** eviCore healthcare at **(888) 693-3211** for prior authorization. Have the pertinent clinical office notes, the member's chart and previous imaging study results available for reference during your call. eviCore healthcare will render a decision within **four hours of receipt** of all necessary information. Please clearly indicate that the prior authorization request is for **medically urgent care**.

### **eviCore healthcare Web-Based Services**

You may access eviCore healthcare online for day-to-day transactions and services. To reach eviCore healthcare online services please go to the Web site, **[www.evicore.com](http://www.evicore.com)**, select your professional group and follow the online instructions. Here you may sign up for access to a variety of eviCore healthcare services, including prior authorization guidelines. Please be sure to watch the Web site for news of future online initiatives.

### **Fax Forms**

You can request additional copies of the fax form by accessing the eviCore healthcare Web site at **[www.evicore.com](http://www.evicore.com)** or by calling the eviCore healthcare Customer Service Department toll-free at **(888) 693-3211, option # 3**.





**§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

**URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]**

- ⓪ ! =Report immediately by telephone (designated by a ♦ in regulations).
- † =Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
- FAX ⓪ ☒ =Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).  
=All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

**REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)**

- Acquired Immune Deficiency Syndrome (AIDS)  
(HIV infection only: see "Human Immunodeficiency Virus")
- FAX ⓪ ☒ Amebiasis
- Anaplasmosis/Ehrlichiosis
- ⓪ ! Anthrax, human or animal
- FAX ⓪ ☒ Babesiosis
- ⓪ ! Botulism (Infant, Foodborne, Wound, Other)
- Brucellosis, animal (except infections due to *Brucella canis*)
- ⓪ ! Brucellosis, human
- FAX ⓪ ☒ Campylobacteriosis
- Chancroid
- FAX ⓪ ☒ Chickenpox (Varicella) (only hospitalizations and deaths)
- Chlamydia trachomatis* infections, including lymphogranuloma venereum (LGV)
- ⓪ ! Cholera
- ⓪ ! Ciguatera Fish Poisoning
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- FAX ⓪ ☒ Cryptosporidiosis
- Cyclosporiasis
- Cysticercosis or taeniasis
- ⓪ ! Dengue
- ⓪ ! Diphtheria
- ⓪ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- FAX ⓪ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ⓪ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
- † FAX ⓪ ☒ Foodborne Disease
- Giardiasis
- Gonococcal Infections
- FAX ⓪ ☒ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
- ⓪ ! Hantavirus Infections
- ⓪ ! Hemolytic Uremic Syndrome
- FAX ⓪ ☒ Hepatitis A, acute infection
- Hepatitis B (specify acute case or chronic)
- Hepatitis C (specify acute case or chronic)
- Hepatitis D (Delta) (specify acute case or chronic)
- Hepatitis E, acute infection
- Influenza, deaths in laboratory-confirmed cases for age 0-64 years
- ⓪ ! Influenza, novel strains (human)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- FAX ⓪ ☒ Listeriosis
- Lyme Disease
- FAX ⓪ ☒ Malaria
- ⓪ ! Measles (Rubeola)
- FAX ⓪ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ⓪ ! Meningococcal Infections
- Mumps
- ⓪ ! Paralytic Shellfish Poisoning
- Pelvic Inflammatory Disease (PID)
- FAX ⓪ ☒ Pertussis (Whooping Cough)
- ⓪ ! Plague, human or animal
- FAX ⓪ ☒ Poliovirus Infection
- FAX ⓪ ☒ Psittacosis

- FAX ⓪ ☒ Q Fever
- ⓪ ! Rabies, human or animal
- FAX ⓪ ☒ Relapsing Fever
- Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- FAX ⓪ ☒ Salmonellosis (Other than Typhoid Fever)
- ⓪ ! Scombroid Fish Poisoning
- ⓪ ! Severe Acute Respiratory Syndrome (SARS)
- ⓪ ! Shiga toxin (detected in feces)
- FAX ⓪ ☒ Shigellosis
- ⓪ ! Smallpox (Variola)
- FAX ⓪ ☒ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
- FAX ⓪ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
- FAX ⓪ ☒ Syphilis
- Tetanus
- Toxic Shock Syndrome
- FAX ⓪ ☒ Trichinosis
- FAX ⓪ ☒ Tuberculosis
- Tularemia, animal
- ⓪ ! Tularemia, human
- FAX ⓪ ☒ Typhoid Fever, Cases and Carriers
- FAX ⓪ ☒ *Vibrio* Infections
- ⓪ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
- FAX ⓪ ☒ West Nile virus (WNV) Infection
- ⓪ ! Yellow Fever
- FAX ⓪ ☒ Yersiniosis
- ⓪ ! OCCURRENCE of ANY UNUSUAL DISEASE
- ⓪ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500).  
Specify if institutional and/or open community.

**HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20**

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and <http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx>

**REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)**

Disorders Characterized by Lapses of Consciousness (§2800-2812)  
Pesticide-related illness or injury (known or suspected cases)\*\*  
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)\*\*\*

**LOCALLY REPORTABLE DISEASES (If Applicable):**

\* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).  
\*\* Failure to report is a citable offense and subject to civil penalty (\$250) (Health and Safety Code §105200).  
\*\*\* The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: [www.ccrca.org](http://www.ccrca.org).  
CDPH 110a (revised 10/03/2011)





# Confidential Communication Request

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) want you to know that you have a choice about your protected health information (PHI). You can have Health Net send any communication that has PHI directly to you instead of the main subscriber of your family's health policy.

**PHI is health information about you. Examples of communications that include PHI are:**

- Explanation of benefits notices.
- Information about your appointments.
- Claim denials, requests for additional information about claims, and notices of contested claims.
- The name and address of your provider, descriptions of services provided and other visit information.

Complete this form if you'd like us to send communications that contain PHI directly to you, instead of the Subscriber, at a different mailing or email address. Note: You may receive notifications regarding Explanation of Benefits, ID cards, information about your claim(s), and provider information via email. If you wish to view this information online, please log in to our secure portal at [www.healthnet.com](http://www.healthnet.com).

**Please mail or FAX this completed form to Health Net. Allow 14 days for us to process your request.**

**MAIL:** Health Net, Membership Accounting, CA-100-04-03, PO Box 9103, Van Nuys, CA 91409-9103

**FAX:** (818) 676-7411, Attention: Health Net Membership Department

**We're here to help!** Please call us if you have questions: **1-800-522-0088**

**Tip!** If you enroll in health coverage with a different company, you will have to let them know how you want your PHI handled.

| Your information   |   |             |
|--|---|-------------|
| First name:  | Last name:  | Birth date: |
| Subscriber ID number:  | Phone number:<br><i>Where we can call you if we have questions?</i> |             |
| Yes! Please send communications with my PHI to this mailing address and/or email address:  |   |             |
| Mailing address:   |   |             |
| City:  | State:  | ZIP:        |
| Email address:   |   |             |
| <small>Note: You will receive notification of Explanation of Benefits, ID cards, information about your claim(s), and provider information via email. If you wish to view this information online, please log in to our secure portal at <a href="http://www.healthnet.com">www.healthnet.com</a>.</small> |   |             |
| I certify and acknowledge that the above information is true and correct.  |   |             |
| Signature:   | Date:   |             |

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# Transitions of Care Management (TRC) Worksheet



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member ID: \_\_\_\_\_

Discharge Facility: \_\_\_\_\_ Admit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PCP or Ongoing Care Provider Name: \_\_\_\_\_

## Transitions of Care – Notification of Inpatient Admission (TRC-NIA)

Date of Admission Notification: \_\_\_\_/\_\_\_\_/\_\_\_\_

Method of Notification:

Phone  Email/Fax  Shared EMR  ADT Feed  HN Provider Portal  HIE Portal

Provider performed a preadmission exam (not pre-op exam) or received notification of a planned admission prior to the admit date.

Other: \_\_\_\_\_

**TRC - Notification of Inpatient Admission: No Administrative Codes available-documentation review required.**

## Transitions of Care – Receipt of Discharge Information (TRC-RDI)

Date of Receipt of Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (includes the day of discharge through 2 days post discharge) TRC-RDI

Method of Notification:

Phone  Email/Fax  Shared EMR  ADT Feed  HN Provider Portal  HIE Portal  Other: \_\_\_\_\_

Discharge Summary Included:  Yes  No

**If discharge summary is not included, complete all information below:**

The practitioner responsible for the member's care during the inpatient stay: \_\_\_\_\_

Procedures of treatment provided: \_\_\_\_\_

Diagnosis at discharge: \_\_\_\_\_

Current medication list: \_\_\_\_\_

Testing results, or documentation of pending tests or no tests pending: \_\_\_\_\_

Instructions for patient care post-discharge: \_\_\_\_\_

**TRC - Receipt of Discharge Information: No Administrative Codes available - documentation review required.**

## Transitions of Care – Patient Engagement (TRC-PE) Please use this as a guide to submit the appropriate codes for services completed.

CPT Copyright 2023 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. TRC - Patient Engagement After Discharge

**Outpatient Visits** If YES, date: \_\_\_\_/\_\_\_\_/\_\_\_\_

CPT Codes Submitted (99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483):  Yes  No

HCPCS Codes Submitted (G0402, G0438, G0439, G0463, T1015):  Yes  No

**Telephone Visits**

CPT Codes Submitted (98966-98968, 99441-99443):  Yes  No

**Online Assessment (e-visit/virtual check-in)**

CPT Codes Submitted (98969-98972, 98980, 98981, 99421-99423, 99444, 99457, 99458):  Yes  No

HCPCS Codes Submitted (G0071, G2010, G2012, G2061-G2063, G2250-G2252):  Yes  No

(continued)

### Administrative codes for MRP

Please use this as a guide to submit the appropriate codes for services completed.

CPT Codes Submitted (99483, 99495, 99496):  Yes  No

CPT CAT II Code Submitted (1111F):  Yes  No

\*\*If Other, Please Explain: \_\_\_\_\_

Do you need help?

No

Submitting CPT/CPTII codes

Member with frequent readmissions

Documentation review

Contacting members

MPR completed and in member's file.

If unable to submit CPT or CPTII code: **Complete the MRP form on the last page.**

### Medication Reconciliation Post-Discharge provider assessment (MRP)

Please use this assessment form to help provide correct documentation needed to close the Medication Reconciliation Post-Discharge (MRP) Healthcare Effectiveness Data and Information Set (HEDIS) measure. Medication reconciliation needs to be completed on the date of discharge through 30 days after discharge (31 days total). After completion, place a copy of the completed form in the patient's record.

#### Member information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member ID: \_\_\_\_\_

Medication Reconciliation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Post-Discharge Hospital Follow-Up Visit:  Yes  No

#### Discharge information

Discharge Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Admission Diagnosis: \_\_\_\_\_

Diagnosis Discharge: \_\_\_\_\_

Facility: \_\_\_\_\_ Hospitalist: \_\_\_\_\_

#### List of medications current and discharge

Document all prescriptions, over-the-counter and herbal supplements below.

Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient was not prescribed any medications upon discharge.

Patient's discharge and current medication list is attached.

| Drug name | Dose at discharge | Frequency |
|-----------|-------------------|-----------|
|           |                   |           |
|           |                   |           |
|           |                   |           |
|           |                   |           |
|           |                   |           |
|           |                   |           |

Provider Name (Print): \_\_\_\_\_

Credentials:  RN  MD  DO  NP/APRN  PA  PharmD  Other: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

If medications were reconciled during office visit, or if this form is completed, please submit Code 1111F to the health plan to capture compliance.

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Health Net Transplant Performance Centers

| Center  | Transplant                         | Type                           | Line of Business |          |         |          | EC PPO  |
|---|------------------------------------|--------------------------------|------------------|----------|---------|----------|---|
|   |                                    |                                | HMO              | Medicare | PPO/EPO | MEDI-CAL |   |
| California Pacific Medical Center - San Francisco   | Kidney                             | Adult                          | X                | X        | X       | X*       | Enhanced Care PPO utilizes OptumHealth Transplant Network |
|   | Kidney-Pancreas                    | Adult                          | X                | X        | X       | X        |   |
|   | Liver                              | Adult                          | X                | X        | X       | X        |   |
|   | Pancreas                           | Adult                          | X                | X        | X       | X        |   |
|   | Liver-Kidney                       | Adult                          | X                | X        | X       | X        |   |
|   | Heart                              | Adult                          | X                | X        | X       | X        |   |
| Cedars-Sinai Medical Center - Los Angeles   | Heart                              | Adult                          | X                |          | X       |          |   |
|   | Kidney                             | Adult                          | X                |          | X       |          |   |
|   | Liver                              | Adult                          | X                |          | X       |          |   |
|   | Stem Cell                          | Autologous                     | X                |          | X       |          |   |
|   |                                    | Allogeneic Related & Unrelated | X                |          | X       |          |   |
| Children's Hospital and Research Ctr at Oakland "Publicly know as UCSF Benioff Children's Hospital Oakland" | Stem Cell                          | Pediatric                      | X                |          | X       |          |   |
|   |                                    | Autologous                     | X                |          | X       |          |   |
|   |                                    | Allogeneic Related             | X                |          | X       |          |   |
| Children's Hospital of Los Angeles  | Heart                              | Pediatric                      | X                |          | X       |          |   |
|   | Liver                              | Pediatric                      | X                |          | X       |          |   |
|   | Kidney                             | Pediatric                      | X                |          | X       |          |   |
|   | Stem Cell                          | Pediatric                      | X                |          | X       |          |   |
|   |                                    | Autologous                     | X                |          | X       |          |   |
| Children's Hospital of Orange County - Orange   | Stem Cell                          | Allogeneic Related & Unrelated | X                |          | X       |          |   |
|   |                                    | Pediatric                      | X                |          | X       |          |   |
|   |                                    | Autologous                     | X                |          | X       |          |   |
| Loma Linda University Medical Center - Loma Linda   | Heart                              | Pediatric                      | X                | X        | X       |          |   |
|   | Kidney                             | Adult                          | X                | X        | X       |          |   |
|   |                                    | Pediatric                      | X                | X        | X       |          |   |
|   | Kidney-Pancreas                    | Adult                          | X                | X        | X       |          |   |
|   |                                    | Pediatric                      | X                | X        | X       |          |   |
|   | Liver                              | Adult                          | X                | X        | X       |          |   |
|   |                                    | Pediatric                      | X                | X        | X       |          |   |
|   | Pancreas                           | Adult                          | X                | X        | X       |          |   |
|   |                                    | Pediatric                      | X                | X        | X       |          |   |
|   | Lucile Packard Children's Hospital | Heart                          | Pediatric        | X        |         | X        |   |
| Heart-Lung  |                                    | Pediatric                      | X                |          | X       | X        |   |
| Kidney  |                                    | Pediatric                      | X                |          | X       | X        |   |
| Kidney-Pancreas   |                                    | Pediatric                      |                  |          |         | X        |   |
| Liver   |                                    | Pediatric                      | X                |          | X       | X        |   |
| Lung  |                                    | Pediatric                      | X                |          | X       | X        |   |
| Pancreas  |                                    | Pediatric                      |                  |          |         | X        |   |
|   |                                    | Pediatric                      | X                |          | X       | X        |   |
| Stem Cell   |                                    | Autologous                     |                  |          | X       | X        |   |
|   |                                    | Allogeneic Related & Unrelated | X                |          | X       | X        |   |
| Rady Childrens Hospital   | Kidney                             | Pediatric                      | X                |          | X       |          |   |
|   | Stem Cell                          | Pediatric                      | X                |          | X       |          |   |
|   |                                    | Autologous                     | X                |          | X       |          |   |
|   |                                    | Allogeneic Related & Unrelated | X                |          | X       |          |   |
|   | Scripps Health - San Diego         | Kidney                         | Adult            | X        | X       | X        |   |
| Liver   |                                    | Adult                          | X                | X        | X       |          |   |
|   |                                    | Adult                          | X                | X        | X       |          |   |
| Stem Cell   |                                    | Autologous                     | X                | X        | X       |          |   |
|   |                                    | Allogeneic Related & Unrelated | X                | X        | X       |          |   |



Health Net Transplant Performance Centers

| Center                                   | Transplant                      | Type                           | Line of Business |          |         |          | EC PPO  |
|--|---------------------------------|--------------------------------|------------------|----------|---------|----------|---|
|  |                                 |                                | HMO              | Medicare | PPO/EPO | MEDI-CAL |   |
| Sharp Healthcare System                  | Heart                           | Adult                          | X                | X        | X       | X        | Enhanced Care PPO utilizes OptumHealth Transplant Network |
|  | Kidney                          | Adult                          | X                |          | X       | X        |   |
| Stanford University Hospital - Palo Alto | Heart                           | Adult                          | X                | X        | X       | X        |   |
|  | Heart-Lung                      | Adult                          | X                | X        | X       | X        |   |
|  | Kidney                          | Adult                          | X                | X        | X       | X        |   |
|  | Kidney-Pancreas                 | Adult                          | X                | X        | X       | X        |   |
|  | Liver                           | Adult                          | X                | X        | X       | X        |   |
|  | Lung                            | Adult                          | X                | X        | X       | X        |   |
|  | Pancreas after Kidney TP        | Adult                          | X                | X        | X       | X        |   |
|  | Stem Cell                       | Adult                          | X                | X        | X       | X        |   |
|  |                                 | Autologous                     | X                | X        | X       | X        |   |
|  |                                 | Allogeneic Related & Unrelated | X                | X        | X       | X        |   |
| Sutter Medical Center Sacramento         | Heart                           | Adult                          | X                | X        | X       | X        |   |
|  | Stem Cell                       | Adult Allogeneic               | X                | X        | X       | X        |   |
|  |                                 | Adult Autologous               | X                | X        | X       | X        |   |
|  |                                 |                                |                  |          |         |          |   |
| UC Davis - Sacramento                    | Kidney                          | Adult Cadaveric & Adult        | X                | X        | X       | X        |   |
|  | Stem Cell                       | Adult                          | X                | X        | X       |          |   |
|  |                                 | Autologous                     | X                | X        | X       |          |   |
|  |                                 | Allogeneic Related & Unrelated | X                | X        | X       |          |   |
| UC San Diego - San Diego                 | Kidney                          | Adult                          | X                | X        | X       | X        |   |
|  | Heart                           | Adult                          | X                | X        | X       |          |   |
|  | Liver                           | Adult                          | X                | X        | X       |          |   |
|  | Lung                            | Adult                          | X                | X        | X       |          |   |
|  | Stem Cell                       | Adult                          | X                | X        | X       |          |   |
|  |                                 | Autologous                     | X                | X        | X       |          |   |
|  |                                 | Allogeneic Related & Unrelated | X                | X        | X       |          |   |
| UCSF - SAN FRANCISCO                     | Heart                           | Adult                          | X                | X        | X       |          |   |
|  |                                 | Pediatric                      | X                |          | X       |          |   |
|  | *Heart-Lung                     | Adult                          | *                | **       | *       |          |   |
|  |                                 | Pediatric                      | *                |          | *       |          |   |
|  | Kidney                          | Adult                          | X                | X        | X       |          |   |
|  |                                 | Pediatric                      | X                |          | X       |          |   |
|  | Kidney-Pancreas                 | Adult                          | X                | X        | X       |          |   |
|  |                                 | Pediatric                      | X                |          | X       |          |   |
|  | Liver                           | Adult                          | X                | X        | X       |          |   |
|  | Lung                            | Adult                          | X                | X        | X       |          |   |
|  | Pancreas                        | Adult                          | X                | X        | X       |          |   |
|  | *Pancreas Autologous Islet Cell | Adult                          | *                | **       | *       |          |   |
|  |                                 |                                |                  |          |         |          |   |
|  | Stem Cell                       | Adult                          | X                | X        | X       |          |   |
|  |                                 | Pediatric                      | X                |          | X       |          |   |
| Autologous                               |                                 | X                              | X                | X        |         |          |   |
| Allogeneic Related & Unrelated           |                                 | X                              | X                | X        |         |          |   |

Health Net Transplant Performance Centers

| Center                             | Transplant      | Type                           | Line of Business |          |         |          | EC PPO  |
|------------------------------------|-----------------|--------------------------------|------------------|----------|---------|----------|---|
|                                    |                 |                                | HMO              | Medicare | PPO/EPO | MEDI-CAL |   |
| Ronald Reagan UCLA Medical Center. | Heart           | Adult                          | X                |          | X       |          | Enhanced Care PPO utilizes OptumHealth Transplant Network |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Kidney          | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Kidney-Pancreas | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Liver           | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Lung            | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Pancreas        | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Small Bowel     | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    | Stem Cell       | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |
|                                    |                 | Autologous                     | X                |          | X       |          |   |
|                                    |                 | Allogeneic Related & Unrelated | X                |          | X       |          |   |
| Liver-Kidney                       | Adult           | X                              |                  | X        |         |          |   |
|                                    | Pediatric       | X                              |                  | X        |         |          |   |
| Keck Hospital of USC.              | Heart           | Adult                          | X                |          | X       |          |   |
|                                    | Heart-Lung      | Adult                          | X                |          | X       |          |   |
|                                    | Kidney          | Adult                          | X                |          | X       |          |   |
|                                    | Liver           | Adult                          | X                |          | X       |          |   |
|                                    | Lung            | Adult                          | X                |          | X       |          |   |
|                                    | Kidney-Pancreas | Adult                          | X                |          | X       |          |   |
|                                    | Stem Cell       | Adult                          | X                |          | X       |          |   |
|                                    |                 | Pediatric                      | X                |          | X       |          |   |

Updated 1.27.22

X = Participating and Blank = Non Par

|  |
|--|
| * Transplant is individually negotiated by Letter of Agreement                 |
| ** Medicare LOB- Transplant is individually negotiated by Letter of Agreement  |
| *** Medi-Cal LOB- Transplant is individually negotiated by Letter of Agreement |





**Request for Necessary Medical Information for Prior Authorization**  
**URGENT REQUEST FOR CONTINUING HOME HEALTH SERVICES**

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

**Patient Information**

|               |                 |
|---------------|-----------------|
| Patient Name  | Subscriber ID # |
| Date of Birth | Today's Date    |

**Provider Information**

|                           |                               |
|---------------------------|-------------------------------|
| Facility Name             | Facility Tax ID #             |
| Telephone #               | Fax                           |
| Requesting Physician Name | ICD-9 Code                    |
| Facility Contact Person   | Telephone # of Contact Person |

In order to process the prior authorization request for home health services regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

**Please ensure that all information is legible and that only standard abbreviations are used.**

|   |
|---|
| <b>SERVICES TO BE PROVIDED</b>  |
| 1. Type of services (for example, wound care, teaching, infusion):          |
| 2. Frequency of services:   |
| 3. How many visits are being requested?                                     |
| 4. How many visits have already been performed?                             |
| 5. a. Start date of service:<br>b. Anticipated completion date of services: |

|  |
|--|
| <b>WOUND CARE</b>  |
| 6. Current size of wound:<br>Length _____ Width _____ Depth _____<br>Type _____ Amount of drainage _____ |

|  |
|--|
| 7. Type of wound care being performed:   |
| 8. Date and type of surgery or description of etiology of wound (for example, diabetic ulcer): |

|   |
|---|
| <b>HOME INFUSION</b>  |
| 9. Type of medication:  |
| 10. Frequency of services:  |
| 11. Is medication also being requested or is this request just for nursing? If medication is also being requested, please attach documentation describing patient's clinical diagnosis and medical records supporting the diagnosis, including applicable lab data. |

|   |
|---|
| <b>HOME IV THERAPY</b>  |
| 12. Type of medication:   |
| 13. Frequency of dosing:  |
| 14. Describe family/patient's ability/inability to self administer: |
| 15. Diagnosis:  |

|   |
|---|
| <b>HOME HEALTH TEACHING</b>   |
| 16. Document teaching needs, date teaching has been performed, and patient/family response to teaching: |

|   |
|---|
| <b>ADDITIONAL QUESTIONS</b>   |
| 17. Other services, please describe:  |
| 18. When will patient be independent in care? What steps are being taken to discharge from service and when is discharge anticipated? |

Please attach physician's order and documentation confirming homebound status and any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department  
**(800) 672-2135**





**Request for Necessary Medical Information for Prior Authorization**

**URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY**

**WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION**

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

**Patient Information**

|               |                 |
|---------------|-----------------|
| Patient Name  | Subscriber ID # |
| Date of Birth | Today's Date    |

**Provider Information**

|                           |                               |
|---------------------------|-------------------------------|
| Facility Name             | Facility Tax ID #             |
| Telephone #               | Fax                           |
| Requesting Physician Name | ICD-9 Code                    |
| Facility Contact Person   | Telephone # of Contact Person |

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

**Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.**

| <b>Occupational and Physical Therapy</b>   |
|--|
| 1. What is the patient's diagnosis (describe in detail)?   |
| 2. What is the patient's dominant hand? Right or left?   |
| 3. What was the exact date of surgery and the exact type of surgery?   |
| 4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31? |
| 5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?          |
| 6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?         |

|  |       |
|--|-------|
| 7. What are the exact physical or occupational therapy modalities being utilized at this time?       |       |
| 8. What was the patient's range of motion at the onset of physical or occupational therapy?          |       |
| 9. What was the patient's range of motion four weeks ago?  | Date: |
| 10. What was the patient's range of motion two weeks ago?  | Date: |
| 11. What is the patient's range of motion now?   | Date: |
| 12. What exercises has the patient been performing?  |       |
| 13. How many repetitions and at what weight was the patient able to perform at the start of therapy? | Date: |
| 14. How many repetitions and at what weight was the patient able to perform four weeks ago?          | Date: |
| 15. How many repetitions and at what weight was the patient able to perform two weeks ago?           | Date: |
| 16. How many repetitions and at what weight is the patient able to perform now?                      | Date: |
| 17. What is the goal range of motion and goal strength?  |       |
| 18. When do you anticipate the member will reach this goal?  |       |
| 19. When do you anticipate the member will be transitioned to a home exercise program?               |       |

| <b>Speech Therapy</b>  |  |
|--|--|
| 1. Please provide the plan of care addressing the following: <ul style="list-style-type: none"> <li>a. The date of onset or exacerbation of the disorder/diagnosis:</li> <li>b. Specific statements of long-term and short-term goals:</li> <li>c. Quantitative objectives measuring current age-adjusted level of functioning:</li> <li>d. A reasonable estimate of when the goals will be reached:</li> <li>e. The specific treatment techniques or exercises to be used in treatment:</li> <li>f. The frequency and duration of treatment:</li> </ul> |  |
| 2. How many speech therapy sessions have been provided this calendar year prior to this request?   |  |
| 3. Is there progress or improvement with the therapy?  |  |

**Please attach any additional documentation supporting this request to the back of this form.**

Fax the requested information to:

Health Net Prior Authorization Department  
**(800) 672-2135**





## Utilization Management Timeliness Standards (Commercial HMO - California)

| Notification Timeframe   |  |   |   |
|--|--|---|---|
| Type of Request  | Decision                                     | Initial Notification<br>(Notification May Be<br>Oral and/or Electronic)   | Written/Electronic Notification<br>of <u>Denial</u> to Practitioner and<br>Member   |
| <b>Urgent Pre-Service</b> –<br>All necessary<br>information received at<br>time of initial request | Within 72 hours of receipt of the<br>request | <u>Practitioner:</u> Within 24<br>hours of the decision, not<br>to exceed 72 hours of<br>receipt of the request (for<br>approvals and denials)<br><br><u>Member:</u> Within 72 hours<br>of receipt of the request<br>(for approval decisions) | Within 72 hours of receipt of the<br>request<br><br><b>Note</b> <ul style="list-style-type: none"> <li>• If oral notification is given<br/>within 72 hours of receipt of<br/>the request, written or<br/>electronic notification must<br/>be given no later than 3<br/>calendar days after the initial<br/>oral notification</li> </ul> |

## Utilization Management Timeliness Standards (Commercial HMO - California)

| Type of Request  | Decision   | Notification Timeframe  |  |
|--|--|---|--|
|  |  | Initial Notification<br>(Notification May Be<br>Oral and/or Electronic)   | Written/Electronic Notification<br>of <u>Denial</u> to Practitioner and<br>Member  |
| <p><b>Urgent Pre-Service – Extension Needed</b></p> <ul style="list-style-type: none"> <li>Additional clinical information required</li> </ul> | <p><b>Additional clinical information required:</b><br/>Notify member and practitioner within 24 hours of receipt of request &amp; provide 48 hours for submission of requested information.</p> <p><u>Additional information received or incomplete</u></p> <ul style="list-style-type: none"> <li>If additional information is <u>received</u>, complete or not, decision must be made within 48 hours of receipt of information</li> </ul> <p><u>Additional information not received</u></p> <ul style="list-style-type: none"> <li>If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours.</li> </ul> | <p><u>Additional information received or incomplete</u></p> <p><b>Practitioner:</b> Within 24 hours of the decision, not to exceed 48 hours after:</p> <ul style="list-style-type: none"> <li>receipt of information (for approvals and denials)</li> </ul> <p><b>Member:</b> Within 48 hours after:</p> <ul style="list-style-type: none"> <li>receipt of information (for approval decisions)</li> </ul> <p><u>Additional information not received</u></p> <p><b>Practitioner:</b> Within 24 hours of the decision, not to exceed 48 hours after:</p> <ul style="list-style-type: none"> <li>the timeframe given to the practitioner &amp; member to supply the information (for approvals and denials)</li> </ul> <p><b>Member:</b> Within 48 hours after:</p> <ul style="list-style-type: none"> <li>the timeframe given to the practitioner &amp; member to supply the information (for approval decisions)</li> </ul> | <p><u>Additional information received or incomplete</u></p> <p>Within 48 hours after:</p> <ul style="list-style-type: none"> <li>receipt of information</li> </ul> <p><u>Additional information not received</u></p> <p>Within 48 hours after:</p> <ul style="list-style-type: none"> <li>the timeframe given to the practitioner &amp; member to supply the information</li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification</li> </ul> |
| <p><b>Non-urgent Pre-Service</b><br/>All necessary information received at time of initial request</p>   | <p>Within 5 business days of receipt of request</p>  | <p><b>Practitioner:</b> Within 24 hours of the decision (for approvals and denials)</p> <p><b>Member:</b> Within 2 business days of the decision (for approval decisions)</p>   | <p>Within 2 business days of making the decision</p>   |



## Utilization Management Timeliness Standards (Commercial HMO - California)

| Notification Timeframe  |  |  |   |
|---|--|--|---|
| Type of Request   | Decision   | Initial Notification<br>(Notification May Be<br>Oral and/or Electronic)  | Written/Electronic Notification<br>of <u>Denial</u> to Practitioner and<br>Member   |
| <p><b>Urgent Concurrent</b> – (i.e., inpatient, ongoing/ambulatory services)</p> <p>Requests involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments</p> <p><b>Exceptions:</b></p> <ul style="list-style-type: none"> <li>• If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to <u>Urgent Pre-service</u> category</li> <li>• If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to <u>Non-urgent Pre-service</u> category</li> </ul> | <p>Within 24 hours of receipt of the request</p>     | <p><u>Practitioner</u>: Within 24 hours of receipt of the request (for approvals and denials)</p> <p><u>Member</u>: Within 24 hours of receipt of the request (for approval decisions)</p> | <p>Within 24 hours of receipt of the request</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification</li> </ul> |
| <p><b>Post-Service</b> - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)</p>   | <p>Within 30 calendar days of receipt of request</p> | <p>Not applicable</p>  | <p>Within 30 calendar days of receipt of request</p>  |

## Utilization Management Timeliness Standards (Commercial HMO - California)

| Notification Timeframe   |  |   |   |
|--|--|---|---|
| Type of Request  | Decision   | Initial Notification<br>(Notification May Be<br>Oral and/or Electronic) | Written/Electronic Notification<br>of <u>Denial</u> to Practitioner and<br>Member   |
| <p><b>Post-Service</b><br/>- Extension Needed</p> <ul style="list-style-type: none"> <li>• Additional clinical information required</li> <li>• Require consultation by an Expert Reviewer</li> </ul> | <p><b>Additional clinical information required:</b><br/>Notify member and practitioner within 30 calendar days of receipt of request &amp; provide at least 45 calendar days for submission of requested information</p> <p><u>Additional information received or incomplete</u></p> <ul style="list-style-type: none"> <li>• If additional information <u>is received</u>, complete or not, decision must be made within 15 calendar days of receipt of information</li> </ul> <p><u>Additional information not received</u></p> <ul style="list-style-type: none"> <li>• If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.</li> </ul> <p><b>Require consultation by an Expert Reviewer:</b></p> <ul style="list-style-type: none"> <li>• If a consultation is required by an expert reviewer, upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer and the anticipated date on which a decision will be rendered</li> <li>• No more than 30 calendar days from the date of the delay notice to the practitioner and member</li> </ul> | <p>Not applicable</p>   | <p><u>Additional information received or incomplete</u></p> <p>Within 15 calendar days:</p> <ul style="list-style-type: none"> <li>• of receipt of information</li> </ul> <p><u>Additional information not received</u></p> <p>Within 15 calendar days after:</p> <ul style="list-style-type: none"> <li>• the timeframe given to the practitioner &amp; member to supply the information</li> </ul> <p>Within 30 calendar days from the date of the delay notice</p> |





# Verifying Eligibility

Individual and Family Plans

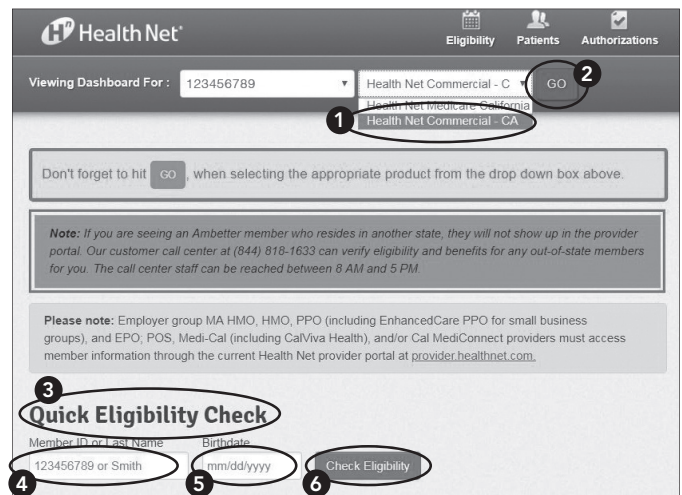
Ramon Munoz  
Health Net

## Verifying member eligibility

Log in to the new secure Health Net\* provider portal at [provider.healthnetcalifornia.com](http://provider.healthnetcalifornia.com), and follow the steps below to verify Individual and Family Plans (IFP) member eligibility. There are two options for verifying eligibility. The second option allows the provider to change the date of service.

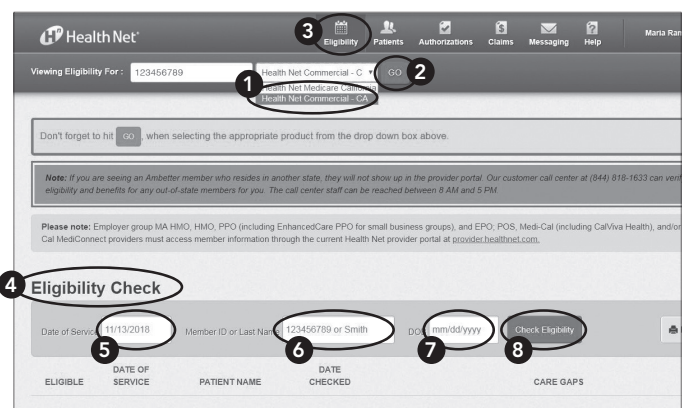
### Option 1

- 1 Use the drop-down menu to choose *Health Net Commercial – CA*.
- 2 Select *Go*.
- 3 Use the Quick Eligibility Check.
- 4 Enter the member's identification (ID) number (or the member's last name).
- 5 Enter the member's date of birth (DOB).
- 6 Select *Check Eligibility* to view the member's information.



### Option 2

- 1 Use the drop-down menu to choose *Health Net Commercial – CA*.
- 2 Select *Go*.
- 3 Select *Eligibility* at the top.
- 4 Use the Eligibility Check.
- 5 Change the date of service (DOS) if you need to verify a DOS for a prior date.
- 6 Enter the member's ID number or the member's last name.
- 7 Enter the member's DOB.
- 8 Select *Check Eligibility* to view the member's information.



(continued)



Verify eligibility at  
[provider.healthnetcalifornia.com](http://provider.healthnetcalifornia.com).





If the IFP member status is not found on the Health Net provider portal at [provider.healthnetcalifornia.com](http://provider.healthnetcalifornia.com), confirm that the member has an IFP.

## Tips

- Include the “R” ID number; use only the letter and numbers listed (R12345678). Do not use MM1 or FS1.
- Include the full “U” ID number as displayed with the first letter and all numbers listed (such as U1234567801 or U1234567802 as listed on the card).
- If searching by last name, include the suffix, such as Jr., as listed on the member’s ID card.
- Remember to also include the DOB since this is a required field.
- If the complete member ID number and DOB were entered and this does not provide eligibility status for the specific member you are verifying, try using the last name and DOB instead.
- If the IFP member status is not found on the Health Net provider portal at [provider.healthnetcalifornia.com](http://provider.healthnetcalifornia.com), confirm that the member has an IFP. If the member has an employer group commercial plan, then verify member eligibility through the original Health Net provider portal at [provider.healthnet.com](http://provider.healthnet.com).

## Viewing Eligibility Check

- 1 The green thumbs-up indicates the member is eligible as of today’s date or the date of service (DOS) entered for the member. (Only enter the DOS if it is not today’s date.) If a thumbs-down appears, it means that the member is not eligible for that date of service, or you may be using the incorrect provider portal based on the member’s plan type.
- 2 The patient name and date checked appear.
- 3 Care gaps are also included, if available.
- 4 An emergency room visit may be added to alert case managers of the member’s recent activity, if applicable.
- 5 There is an option to also print the eligibility information for your records.
- 6 Select the hyperlink, which is the member’s name, for additional patient information.
- 7 If you need to verify eligibility for another member, enter the member’s ID number (or the member’s last name) and DOB, and select *Check Eligibility*.
- 8 **Optional:** Participating physician groups (PPGs) may complete eligibility checks for members currently included in their group. If the member is not eligible, use the *Remove* button to delete that member before printing the list of eligible members.

Health Net

Viewing Eligibility For: 123456789 Health Net Commercial - C GO

Don't forget to hit [Go](#) when selecting the appropriate product from the drop down box above.

**Note:** If you are seeing an Ambetter member who resides in another state, they will not show up in the provider portal. Our customer call center at (844) 818-1633 can verify eligibility and benefits for any out-of-state members for you. The call center staff can be reached between 8 AM and 5 PM.

**Please note:** Employer group MA HMO, HMO, PPO (including EnhancedCare PPO for small business groups), and EPO, POS, Medi-Cal (including CalViva Health), and/or Cal MediConnect providers must access member information through the current Health Net provider portal at [provider.healthnet.com](http://provider.healthnet.com).

### Eligibility Check

Date of Service: 11/13/2018 Member ID or Last Name: 123456789 or Smith DOB: mm/dd/yyyy [Check Eligibility](#) [Print](#)

| ELIGIBLE | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | CARE GAPS | Emergency Room Visit   |
|----------|-----------------|--------------|--------------|-----------|------------------------|
|          | 11/13/18        | Jane Doe     | 11/13/2018   |           | <a href="#">Remove</a> |

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