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

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

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

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

References

For more information, refer to:

- ACEs Aware
- Health Care Toolbox

Toxic Stress

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

References

For more information, refer to:

- ACEs Aware
- California All
- CFAP
- Healthy Children

Positive Parenting and Resilience Building

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

- **ACEs Connection**: News and information on ACEs and how to become more trauma-informed in practice.
- **The Center for Youth Wellness:** Led by Nadine Burke-Harris, MD, the Center for Youth Wellness is an international leader in addressing ACEs in practice.

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

Screen for ACEs

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

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

For children and adolescents, use PEARLS.

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

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

For adults, use the ACE assessment tool.

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

Use of tools

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

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.	Not given more than once during a 12-month period, per provider, per member under age 21. Not given more than once per lifetime, per provider, per member ages 21 and older.

The approved tools are available in two formats:

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

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

Administering the screening

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

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

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

References

For more information, refer to:

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

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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

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

ACEs resources

Free ACEs resources for providers on screening and clinical response.

Behavioral Health Services

For Health Net:

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

Case Management

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

Health Net Community Connect

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

To use the tool, Health Net members should go to healthnet.findhelp.com, enter a ZIP code and click Search.

myStrength

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

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

Health Education Materials

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

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

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

References

For more information, refer to:

- ACEs Screening Sample Scripts for Pediatric Clinical Teams
- ACEs Aware treatment
- ACEs Screening Clinical Workflows and Assessment Algorithm
- ACEs Aware resources

ACE Training and Self-Attestation Requirement for Billing

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

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

How to receive payments for ACE screenings

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

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

Existing and future trainings on ACEs

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

Appeals, Grievances and Disputes

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

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

Select any subject below:

- Member Appeals
- Provider Appeals and Dispute Resolution
- Grievances

Member Appeals

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

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

Select any subject below:

- Member Appeals Overview
- Appeal Process
- Investigational or Experimental Treatment

Member Appeals Overview

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

Health Net members are entitled to have their appeals or grievances addressed by Health Net and have a contractual right to claims arbitration for claims that are not resolved to their satisfaction. Health Net does not delegate appeals or grievances to participating providers. If the participating provider becomes aware of a member appeal, the participating provider must fax the appeal to the Health Net Member Appeals and Grievance Department within one business day. Health Net's process includes peer-review-protected evaluations on the matters raised. A copy of the denial and relevant clinical information needs to be submitted with appeal requests. Health Net's grievance and appeal process includes peer-review-protected evaluation of the matters raised.

Grievances are a verbal or written statement, other than one that is an organization determination, expressing dissatisfaction regarding any aspect of an organization's or participating provider's operations, contractual issues, activities, or behavior. A grievance is generally further classified as either a quality-of-care or quality-of-service issue.

An appeal or request for reconsideration is a verbal or written request to change a previous service decision or adverse determination. The request can be from a member, a participating provider or a member representative and is categorized as either a pre-service, post-service, expedited, or external review.

The fact that a member submits an appeal or grievance to Health Net or the participating provider should not affect in any way the manner in which the member is treated by the participating provider. If Health Net discovers that any improper action has been taken against such a member by the participating provider, Health Net takes immediate steps to prevent such conduct in the future. These steps involve appropriate sanctions, including possible termination of the applicable Provider Participation Agreement (PPA).

Health Net requires that all participating providers provide all pertinent appeal or grievance documentation to the Health Net Member Appeals and Grievance Department by fax or mail within five calendar days of the participating providers' receipt of Health Net's request for information. Health Net expects the participating provider to review the matter promptly and work with Health Net on corrective actions needed as part of the overall quality improvement process. If the participating provider does not provide the necessary documentation, Health Net may be obligated to make a determination in the member's favor.

Refer to Appeal, Grievance, Complaint, or Inquiry as applicable for additional information.

Expedited

An expedited appeal is warranted if there is a time-sensitive situation where an adverse decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, defined as cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Expedited appeals includes pre-service appeals, a terminally ill appeal for a request for reconsideration of treatment, services or supplies deemed experimental as recommended by a participating provider, or a life-threatening or seriously debilitating condition appeal.

All expedited appeals that meet the above definition are processed within 72 hours from the time the request is received by the participating provider or Health Net.

Financial Responsibility

Financial responsibility determinations are made consistent with the terms of the Provider Participation Agreement (PPA) and Health Net policy. If, during an appeal, Health Net or the independent medical review (IMR) overturns a denial, the responsible participating provider provides the service and pays the claim as stated in the PPA.

Binding Arbitration Process

Sometimes disputes may arise between a member and Health Net regarding the construction, interpretation, performance, or breach of the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI), or regarding other matters relating to or arising out of membership. Typically such disputes are handled and resolved through the Health Net appeal, grievance or independent medical review (IMR) processes. However, in the event that a dispute is not resolved, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties, such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition of membership, Health Net members agree to submit all disputes against Health Net, except those described later, to final and binding arbitration. Health Net agrees to arbitrate all of these disputes. This mutual agreement to arbitrate disputes means that both the member and Health Net use binding arbitration as the final means of resolving disputes that may arise between them, and forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law are forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate is enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrators selected by Health Net and the member. The Federal Arbitration Act, 9 U.S.C.1, et sea., governs arbitrations under this process. If the total amount of damages claimed is $200,000 or less, Health Net and the member must, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who hears and decides the case and who cannot award more than $200,000. In the event that the total amount of damages is more than $200,000, Health Net and the member must, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless they mutually agree to one arbitrator), who hears and decides the case.

If Health Net and the member fail to reach an agreement during this time frame, then either may apply to a Court of Competent Jurisdiction for appointment of the arbitrators to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net's litigation administrator. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret the Health Net member's EOC or COI, but does not have any power to change, modify or refuse to enforce any of its terms, nor can the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator issues a written opinion and award providing findings of fact and conclusions of law. The award is final and binding on Health Net and the member, except to the extent that state or federal law provides for judicial review of arbitration proceedings.

Health Net and the member share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each is also responsible for their own attorneys' fees. In cases of extreme hardship to a member, Health Net may assume all or a portion of a member's share of the fees and expenses of the arbitration. Upon written notice by the member requesting a hardship application, Health Net forwards the request for hardship to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the litigation administrator.

Members enrolled in an employer-sponsored health plan that is subject to ERISA, 29 U.S.C. 1001 et seq. are not required to submit disputes about certain adverse benefit determinations to binding arbitration. However, the member and Health Net may voluntarily agree to resolve adverse benefit determinations through the arbitration process.

Appeal Process

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

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.

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

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
- 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

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 30th calendar day indicating the reason for the delay and providing an estimated resolution date. The written resolution is made as soon as possible and not to exceed 15 additional calendar days.

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

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

DMHC Notices of Translation Assistance, Forms and Applications

DMHC Notices of Translation Assistance

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

Translated DMHC Complaint (Grievance) Forms

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

Translated DMHC IMR Applications

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

Ancillary Providers and Notice of Language Assistance

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

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Benefits

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

This section contains general member benefit information.

Benefits in Alphabetical Order

Select any subject below:

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

A

B

C

D

E

F

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
- 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
- Covered Services

Acupuncture Services

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

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

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

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

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

Coverage Criteria

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

Additional services in subsequent visits may include:

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

The following information applies to PPO members.

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

Coverage Criteria

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

Additional services in subsequent visits may include:

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

Exclusions and Limitations

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

Covered Services

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

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

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

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

Alcohol and Drug Abuse

Provider Type: Physicians | 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

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

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

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

Exclusions and Limitations

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

Substance Abuse Facilities

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

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

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

Substance Abuse Facilities - Outpatient

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

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

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

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

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

- Professional and other trained staff and ancillary services provided in the facility that are necessary for treatment of the ambulatory patient.
- Individual and group therapy or counseling.
- Family counseling, with each visit by one or more family members of the Health Net member being deducted from the member's outpatient behavioral health consultation benefit for the calendar year.

- Laboratory tests required in connection with the treatment received at the facility.
- Medications, biologicals, solutions, and supplies dispensed by the facility in connection with treatment received at the facility, including medications to be taken home.
- Psychological testing by a person legally qualified to administer and interpret such tests. Where there are no licensure laws, the psychologist must be certified for psychological testing by the appropriate professional body (subject to prior review for medical necessity).

Substance Abuse Rehabilitation Services

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

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

Substance Abuse Rehabilitation Exclusions and Limitations

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

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

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)

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.

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

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.

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

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 professiona” means an individual who meets all of the following criteria:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- Is supervised by a qualified autism service provider.
- Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Is either of the following:

- A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program, or meets the criteria set forth in the regulations adopted pursuant to subdivision (a) of Section 4686.4 of the Welfare and Institutions Code for a behavioral health professional.
- A psychology associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

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

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

Educational Services

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.

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.

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 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

Behavioral Health

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

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

Select any subject below:

Overview

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

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

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

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

- Care management and quality improvement

Copayment

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

Criteria for Behavioral Health and Substance Abuse Treatment

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

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

Coordination of Care

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

the medical record consisting of the content of conversation during a private, group, joint, or family counseling session).

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

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

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

Day Care Treatment

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

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

Dual Diagnosis

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

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

Employee Assistance Program

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

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

Exclusions

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

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

- Non-treatable disorders: Mental disorders or substance abuse conditions that Health Net determines are not likely to improve with generally accepted methods of treatment or conditions excluded from coverage.
- State hospital treatment: Treatment or confinement in a state hospital are limited to treatment or confinement as the result of an emergency or urgent care.
- Non-standard therapies: Services that do not meet national standards for professional mental health practice, such as Erhard/The Forum, primal therapy, bioenergetics therapy, crystal healing therapy and therapies deemed experimental or investigational by medical policies.
- Psychological testing: Psychological testing for learning disabilities, academic difficulties, and educational achievement testing are not covered. Testing for attention deficit hyperactivity disorder (ADHD) as a single diagnosis, or not part of diagnostic clarification is also not a covered benefit. Psychological testing must be conducted by a licensed psychologist or psychiatrist, and must be medically necessary to diagnose or treat a mental health disorder.

- Prescription medications: Outpatient prescription medications or over-the-counter medications.
- Private-duty nursing: Private-duty nursing services in the home or in a hospital

- Insurance: Services for obtaining or maintaining insurance.
- Aversion therapy: Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus.
- Treatment for co-dependency: Treatment for co-dependency services, unless they are provided for a treatable mental disorder.
- Wilderness programs or therapeutic boarding schools not licensed as residential treatment centers.
- Non-participating providers: Services provided by mental health professionals or facilities not contracting with Health Net, except in those cases where Health Net refers a member to a non-participating provider or authorizes emergency or urgently needed care.
- Treatment by a relative: Treatment or consultation provided by the member's parents, siblings, children, current or former spouse, or any adults who live in the member's household.
- Education and employment services: Services related to educational, vocational and professional purposes, including:
    - Treatment of learning disabilities, borderline intellectual functioning and mental retardation.
    - Vocational rehabilitative education.
    - Investigations required for employment.
    - Education for maintaining employment or for professional certification.
    - Education for personal or professional growth, development or training, including vocational counseling.
    - Academic education during residential treatment.
- Testing, screening or treatment for learning disabilities.
- Specialized treatment program for smoking cessation, weight reduction, obesity, stammering, stuttering, or sexual addiction.

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

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

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

General Guidelines for Referrals

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

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

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

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.

Blood

Provider Type: Physicians | Participating Physician Groups (PPG)

Blood and blood plasma, and derivatives are covered.

This coverage includes all of the following:

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

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

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

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.

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
- 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
- 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

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

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

Cleft Palate Diagnoses

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

Treatment for cleft lip/palate as covered under California Children's Services (CCS). Cleft palate may also include, cleft lip or other craniofacial anomalies associated with cleft palate. Health Net covers medically necessary services that are an integral part of cleft palate reconstruction and are not approved by CCS. To the

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

Cleft palate reconstruction services require prior authorization.

Dental Services

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

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

Select any subject below:

- 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.

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.

General Anesthesia Coverage and Exclusions

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

General Anesthesia Coverage

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

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

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

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

General Anesthesia Exclusions

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

Dialysis

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

This section contains general member benefit information on dialysis.

Select any subject below:

- Overview

Overview

Provider Type: Physicians | 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

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.

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.
- Numotion.

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

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

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

Essential Health Benefits

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

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

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

Actual EHB services vary by state, as each state may define EHB in accordance with its state benchmark plan. Plans subject to the EHB requirement must provide benefits that are equal to or greater than the state benchmark plan's benefits. Annual dollar limits on EHB are prohibited. Additional information regarding state benchmark plans is available on the Center for Consumer Information and Insurance Oversight (CCIIO) website at www.cms.gov/cciio/index.html.

Family Planning

Provider Type: Physicians | 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.

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

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

Intrauterine Devices

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

Exclusions and Limitations

The following are exclusions and limitations on family planning coverage:

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

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

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:

- 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.

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
- 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
  - Dental implants
  - Bridgework (to treat dental conditions related to TMJ disorder)
  - Braces and active splints for orthodontic purposes (movement of teeth)
- Disposable supplies - Disposable supplies for home use are not covered (for example, plastic gloves, diapers, incontinence pads, and wipes). Coverage for outpatient prescription medications includes coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription medication, such as spacers and inhalers for the administration of aerosol outpatient prescription medications, and syringes for self-injectable outpatient prescription medications that are not dispensed in pre-filled syringes
- Experimental or investigative services and supplies - All services and supplies not generally recognized under standards of care in the medical community are not covered, except for routine patient care costs associated with participation in clinical trials for a Health Net member with a diagnosis of cancer and has the recommendation of their treating physician. The exclusion from coverage does not include treatment of medical complications relating to, or arising out of, such services and supplies. Health Net decides whether a service or supply is experimental or investigational
- Eyeglasses and contact lenses - Contact lenses (except an implanted lens that replaces the organic eye lens) and eyeglasses are not covered, unless specifically provided in the member's EOC
- Genetic testing and diagnostic procedures - Covered when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. Genetic testing is not covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality. Every health care service plan contract that covers hospital, medical or surgical expenses through an employer group, and which offers maternity coverage in such groups, also offers coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Hearing aids - Any device inserted in or affixed to the outer ear to improve hearing is not covered, unless specifically provided in the member's EOC

- Ineligible status - Services or supplies provided before the effective date of coverage or after the date coverage has ended are not covered, except as specified in the extension of benefits portion of the member's EOC
- No-charge items - Services or supplies the member is not required to pay for or for which no charge is made are not covered
- Non-covered items - Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the Schedule of Benefits to determine exclusions, limitations and applicable copayments. Non-covered items are:
- Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, treadmills, free weights
- Supplies to achieve cleanliness even when related to other medical services
- Surgical dressings, except primary dressings that are applied directly to lesions either of the skin or surgical incision, which are covered as a standard medical benefit. Over-the-counter dressings and supplies are not covered
- Jacuzzis and whirlpools
- Stockings, such as elastic stockings, job stocking and support hose, garter belts and similar devices, as not within the definition of brace
- Orthotics that are not custom-made to fit the member's body. Orthotics are orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belts
- Corrective footwear (specialized shoes, arch supports and inserts) except for the treatment of diabetes-related medical conditions or as specifically provided in the member's EOC
- Non-eligible institutions - Services or supplies provided by any institution other than a licensed and approved hospital or Medicare-approved skilled nursing facility (SNF) or other properly licensed facility specified as covered in the member's EOC are not covered. Any institution that is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated, is not an eligible institution
- Non-prescription (over-the-counter) medications, equipment and supplies - Any medication, equipment and supplies that can be purchased without a prescription order is not covered, even if a physician writes a prescription for it (except insulin and diabetic supplies or as specifically provided in the EOC)
- Personal or comfort items - Personal or comfort items such as a telephone or television in the room at a hospital or SNF are not covered
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility
- Private rooms - Private rooms in a hospital or SNF are not covered unless it is deemed to be medically necessary
- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism, is not covered
- Reversal of surgical sterilization - Reversal of a prior voluntary surgical sterilization procedure is not covered
- Routine physical examinations - Routine physical examinations are not covered for insurance, licensing, employment, school, camp, or other non-preventive purposes, unless specifically provided otherwise in the EOC. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms are not covered. Refer to the specific plan in the Schedule of Benefits
- Services for obtaining or maintaining insurance are not covered
- Sterilization is not covered for males and females. Refer to the specific plan in the Schedule of Benefits or EOC for exceptions

- Substance abuse - Treatment of chronic alcoholism, drug addiction and other substance abuse problems, except for acute detoxification and the acute medical treatment of these problems. Other services not covered include: non-medical ancillary services; prolonged rehabilitation services, including inpatient, residential and outpatient substance abuse program; psychological counseling and aversion therapy. The terms and conditions applied to these benefits must be the same as those applied to other medical benefits under the plan contract due to federal mental health parity laws. Refer to the specific plan in the Schedule of Benefits for exceptions
- Unauthorized services and supplies - Any services or supplies not authorized according to procedures Health Net and the participating physician group (PPG) have established are not covered
- Unlisted services - Services or supplies that are not specified as covered services or supplies are not covered, unless coverage is required by law

General Benefit Exclusions and Limitations (Physicians Only)

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

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

work, onlays, inlays, dental implants, braces, and any orthodontic appliances are not covered unless specifically provided in the member's EOC

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

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

Genetic Testing

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

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

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

Genetic Testing Coverage

Medically necessary genetic testing is covered for the following conditions:

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

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

Indications for Covering Genetic Testing

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

- Unexplained developmental delay or mental retardation
- Unusual facial appearance or other dimorphic features, especially accompanied by failure to thrive or sub-optimal psychomotor development
- Movement disorder

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

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

Hearing

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

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

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

Hearing Aid

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

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

When hearing aids are a covered benefit, coverage includes a standard hearing device, analog or digital, inserted into the canal or affixed to the outer ear to restore adequate hearing to the member and as determined to be medically necessary by a Health Net participating provider or audiologist. This includes repair and

maintenance of the devices at no cost to the member. Plans may limit the number of hearing aids or covered charges permitted in a certain time period.

Exclusions and Limitations

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

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

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

Home Health Care

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

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

Home Health Care Services

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

The following are additional components of home health care:

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

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

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

Service Providers

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

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

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

Homebound Determination

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

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

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

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

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

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

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

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

not required. Requests for visits for members discharged after 48 hours are evaluated on a case-by-case basis for medical necessity.

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

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

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

Exclusions and Limitations

The following are not covered:

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

Authorization Guidelines

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

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

- mental status of member
- types of services and equipment required (including frequency, duration, dressings, injections, and treatments)
- frequency of visits
- prognosis
- rehabilitation potential
- activities performed
- nutritional requirements
- medications and treatments (including amount, frequency and duration)

- homebound status
- any safety measures to protect against injury
- instructions for timely discharge or referral
- any other relevant items

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

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

Physician Certification

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

Physician Recertification

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

Ongoing Care

Participating providers initiate home health care services as follows:

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

For more information, select any subject below:

- Skilled Nursing Services

Skilled Nursing Services

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

The following are skilled services other than skilled nursing services:

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

Skilled Nursing Observation and Evaluation

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

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

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

Information from the member's home health record must document that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the three-week period. Signs and symptoms, such as abnormal or fluctuating vital signs, weight changes, edema, symptoms of medication toxicity, abnormal/fluctuating lab values, and respiratory

changes on auscultation, may justify skilled observation and assessment. When these signs and symptoms demonstrate reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the member's treatment, then services are covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the member's illness or injury where fluctuating signs and symptoms have been part of a longstanding pattern of the member's condition, which has not previously required changes to the prescribed treatment.

Hospice Care

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

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

Select any subject below:

- Hospice Services
- Claims Submission
- Hospice Agency
- Interdisciplinary Team
- Prior to Election of Hospice Services

Hospice Services

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

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

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

Description

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

- Professional services of a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy and speech therapy

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

Hospice Consideration Request

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

Certification of Terminal Illness

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

Hospice Referrals

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

Medications, Medical Equipment, and Supplies

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

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

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

Short-Term Inpatient Care

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

Short-term inpatient care is considered acute care hospitalization.

Skilled Nursing Services

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

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

Counseling Services

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

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

Bereavement Counseling

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

Period of Crisis

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

Respite Care

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

Volunteer Services

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

Claims Submission

Provider Type: Physicians | 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 though 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.

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.

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 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 form 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
- 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.

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:

- Start Smart for Your Baby Care Management
- Maternal Mental Health Screening Requirement
- Pediatric Services

Start Smart for Your Baby Care

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

PROFESSIONAL CARE FOR PREGNANCY

Hospital and professional pregnancy services are covered, including:

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

- Continuation of obstetrical services for terminated members. If a female member is terminated from a Health Net group agreement, coverage for obstetrical services is provided when there is a continuation of coverage through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the conversion plan.

GENETIC TESTING AND COUNSELING

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

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

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

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

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

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

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

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

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

Maternal Mental Health Screening Requirement

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

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

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

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

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

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

Pregnancy Program

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

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

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

Pediatric Services

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

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

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

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

Medical Social Services

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

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

Select any subject below:

- Coverage Explanation

Coverage Explanation

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

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

Nuclear Medicine

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

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

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

Nurse Midwife

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

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

Select any subject below:

- Coverage

Coverage

Provider Type: Physicians

A certified nurse midwife (CNM) is a registered nurse who has received training in obstetrics and gynecology, and is certified by the American College of Nurse Midwives. A midwife assists in delivering infants, as well as providing antepartum and postpartum care. CNMs must be licensed by the state of California and working under the license of an actively practicing physician. CNM coverage is limited to services performed within the scope of a CNM's license and according to the terms of the member's plan. Home births are not covered. Services rendered by 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 85th percentile and lower than the 95th percentile is defined as overweight. Considerations for obesity is having a BMI at the 95th percentile or above.

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

Coverage

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

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

Resources

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

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

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

The following information does not apply to Medi-Cal

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

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

For more information on, select any subject below:

Bariatric Surgery Services

Bariatric Surgery Services

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

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

Outpatient Services

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

This section contains general member benefit information on outpatient services.

Select any subject below:

- Coverage Explanation

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

Breast Cancer Susceptibility Gene Testing

Provider Type: Physicians

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

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

Hepatitis C Screening

Provider Type: Physicians

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

Mammography

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

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

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

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

Claims coding for DBT:

CPT Codes	Description
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
77063	Screening digital breast tomosynthesis, bilateral
HCPCS Codes	Description
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral

Preventive Services Guidelines

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

As new preventive care recommendations/guidelines are released by the USPSTF, ACIP and HRSA, they will ultimately be added to our list of covered preventive care benefits. *Note: All newly released preventive care recommendations/guidelines must be applicable to group health plans and health insurance issuers for plan*

years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

On our commercial individual & family, small and large group plans, with the exception of grandfathered plans[1], preventive care benefits obtained from an in-network provider are covered without member cost share (i.e., covered in full – without a deductible, coinsurance or copayment). Please keep in mind, certain covered services can be performed for preventive or diagnostic reasons (e.g., mammograms). Therefore, how such services are billed – preventive or diagnostic – will determine the applicable benefit category and cost share. Furthermore, if preventive and diagnostic services are performed during the same visit, cost share may apply to the latter (depending on the plan design).

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

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

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

Prosthesis

Provider Type: Physicians | 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).
- Used in place of normal food products, such as foods from the grocery store that are used by the general population.

For additional information regarding the coverage of treatment of PKU, refer to the Coverage Explanation document.

Coverage Explanation

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

Prostheses are covered on most plans. Prostheses needs may be referred to any Health Net participating provider.

Prostheses and supplies include:

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

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

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

Formula is covered under the prostheses benefit as follows:

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

Rehabilitation Therapy

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

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

Select any subject below:

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

Coverage Explanation

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

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

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

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

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

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

Home Health Services

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

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

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

Physical, Occupational or Speech Therapy Services Concurrent Review Forms

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

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

Support for Disabled Members

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

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

Select any subject below:

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

Americans with Disabilities Act of 1990

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

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

Auxiliary Aids and Services

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

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

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

Effective Communication

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

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

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

Financial Responsibility

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

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

Undue Burden

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

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

Surgery, Surgical Supplies, and Anesthesia

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

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

Select any subject below:

- Coverage Explanation
- 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 anesthetist or anesthesiologist, including administration of anesthetics in conjunction with surgical services in the hospital.

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

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

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

Exclusions and Limitations

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

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

TMJ

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

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

Covered Services

Coverage of TMJ is limited to the following:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw when such procedures are medically necessary.

- Custom-made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD or TMJ disorders are covered if medically necessary.

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

Exclusions and Limitations

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

For more information, select any subject below:

- Payment MEDICARE 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).

Transgender Services

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

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

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

- Consultation with transgender service providers.
- Transgender services work-up and preparation.
- Psychotherapy.

- Continuous hormonal therapy.
- Laboratory testing to monitor hormone therapy.
- Gender reassignment surgery that is not cosmetic in nature.

Medically Necessary/Reconstructive Surgery

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

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

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

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

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

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

1. A properly trained (in behavioral health) and competent (in assessment of gender dysphoria) professional has diagnosed the member with gender dysphoria or GID.

2. The individual is under feminizing hormonal therapy.
3. The medical necessity for hair removal has been determined according to the judgment of a qualified mental health professional and the referring physician.

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

Requesting Services

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

Transplants

Provider Type: Physicians | 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

Overview

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 allogenic stem cell and autologous stem cell) requests must be submitted by the transplant service provider directly to the Centene Centralized Transplant Unit (CTU) for review. Requests received from the primary care physician (PCP) 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.

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

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

Performance Requirements

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

Required Accreditation

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

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

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

Two Levels of Participation –

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

Volume Criteria

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

Minimum Transplant Volume required per calendar year:

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

Survival/Outcomes Criteria:

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

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

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

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

Blood and Marrow –

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

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

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

Health Net Transplant Performance Centers

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

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

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

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)

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).

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

Laboratory Services

Provider Type: Physicians

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

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

- Medicare Advantage (MA)
- Medi-Cal

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

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

Radiation Therapy

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

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

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

Claims and Provider Reimbursement

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

This section describes claims and provider reimbursement

Select any subject below:

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

Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

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

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

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

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

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

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

Accessing Claims on the New Health Net Portal

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

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

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

Adjustments

Provider Type: Physicians | Ancillary

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

Balance Billing

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

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

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

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

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

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

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

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

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

For more information, select any subject below:

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

Billing and Submission

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

This section contains general information on claims billing and submission.

Select any subject below:

Claims Receipt Acknowledgement

Provider Type: Physicians | Ancillary | Hospitals

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

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

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

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

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

Claims Submission

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

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

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

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

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

Claims Submission Requirements

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

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

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

Refer to un-clean claims for more information.

Acceptable Forms

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

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

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

Electronic Claims

For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction. Each claim submitted must include all mandatory

elements and situational elements, where applicable. Secondary COB claims can be sent electronically with all appropriate other payer information and paid amounts.

Paper Claims

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

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

Professional Claims

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

Institutional Claims

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

Medicare Billing Instructions

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

Mandatory Items for Claims Submission

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

Reference guide for commonly submitted items

Form Fields	Electronic	CMS-1500	UB-04
Billing provider tax ID	Loop 2010AA REF segment with TJ qualifier	Box 25	Box 5
Billing provider name, address and NPI	Loop NM109 with XX qualifier	Box 33	Box 1
Subscriber (name, address, DOB, sex, and member ID required)	2000B and 2010BA	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Provider taxonomy		Box 33B and Box 24	Box 57
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	2000C and 2010CA	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Principal diagnosis and additional diagnoses	Loop 2300 HI segment qualifier BK (ICD9) or ABK (ICD10)	Box 21	Box 66
Diagnosis pointers (up to 4)	Loop 2410 SV107	Box 24E (A-L)	N/A
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76

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

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

Claims Rejection Reasons and Resolutions

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

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

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

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

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

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

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

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

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

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

The documentation of each patient encounter should include the following:

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

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

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

CMS-1500 Billing Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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® 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

Hospital-acquired conditions (HACs) are a set of hospital complications and medical errors that may cause severe consequences. They occur during a hospital stay (are not present at the time of admission) and can reasonably be prevented through the application of appropriate evidence-based protocols. These events may result in more serious outcomes to the member, including loss of function, disability and death. Their occurrence may also prolong hospital stays.

Billing Instructions

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

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

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

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

Indicator	Description
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission

Indicator	Description
W	Provider is unable to clinically determine whether condition was present on admission or not
1	Exempt from POA reporting (equivalent of a blank code on UB-04/CMS 1450 form). This code should rarely be used and every effort to determine the appropriate indicator must be made

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

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

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

Quality Improvement HAC Program

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

HAC Confirmation

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

- Determine if the event was potentially preventable and within the control of the hospital and the medical staff who provided care during the member's stay.

- Agree to refrain from billing or adjust billing to Health Net or the member for any charges associated with the HAC if it is determined that the HAC was preventable.
- Perform a root cause analysis and take measures to prevent recurrences as necessary.

HAC Notification

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

Trauma Services

Provider Type: Hospitals

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

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

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

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

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

UB-04 Billing Instructions

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

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
3b	Medical record number	Enter the facility patient medical or health record number	Required
4	Type of bill	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit - Indicating the type of facility. 2nd Digit - Indicating the type of care. 3rd Digit- Indicating the bill sequence (frequency code).	Required
5	Fed Tax No	Enter the nine-digit number assigned by the federal government for tax reporting purposes	Required
6	Statement covers period from/through	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology,	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	
7	Unlabeled field	Not used.	Not required
8a	Patient name	8a - Enter the first nine digits of the identification number on the member's ID card.	Not required
8b		Enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Enter the patient's complete mailing address.	
9	Patient address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (NOT REQUIRED)	Required - Except line 9e county code
10	Birthdate	Enter the patient's date of birth (MMDDYYYY)	Required - Ensure DOB of patient is entered and not the insured)
11	Sex	Enter the patient's sex. Only M or F is accepted	Required
12	Admission date	Enter the date of admission for inpatient claims and date of service for outpatient claims (MMDDYY)	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.
13	Admission hour	Enter the time using two-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a..m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	082x require boxes 12–13 to be populated.
14	Admission type	Require for inpatient and outpatient admissions. Enter the one-digit code indicating the type of the admission using the appropriate following codes: • 1 - Emergency • 2 - Urgent • 3 - Elective • 4 - Newborn • 5 - Trauma	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
15	Admission source	Required for inpatient and outpatient admissions. Enter the one-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: • 1 - Physician referral • 2 - Clinic referral • 3 - Health maintenance referral (HMO) • 4 - Transfer from a hospital • 5 - Transfer from skilled nursing facility • 6 - Transfer from another health care facility • 7 - Emergency room • 8 - Court/law enforcement • 9 - Information not available For type of admission 4 (newborn): • 1 - Normal delivery • 2 - Premature delivery • 3 - Sick baby	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 4 - Extramural birth • Information not available	
16	Discharge hour	Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a.m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	Conditional - Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		billing period listed in field 6 using one of the following codes: • 01 - Routine discharge • 02 - Discharged to another short-term general hospital • 03 - Discharged to SNF • 04 - Discharged to ICF • 05 - Discharged to another type of institution • 06 - Discharged to care of home health service organization • 07 - Left against medical advice • 09 - Discharged/ transferred to home under care of a home IV provider • 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) • 20 - Expired or did not recover • 30 - Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment	

Field number	Field description	Instruction or comments	Required, conditional or not required
		is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown (hospice use only) • 43 - Discharged/ transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) • 50 - Hospice-Home • 51 - Hospice-Medical Facility • 61 - Discharged/ transferred within this institution to a hospital-based Medicare approved swing bed • 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part	

Field number	Field description	Instruction or comments	Required, conditional or not required
		units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility certified under Medicaid but not certified under Medicare • 65 - Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital • 66 - Discharged/ transferred to a critical access hospital (CAH)	
18-28	Condition codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric	Conditional REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
37	Unlabeled field	REQUIRED for re-submissions or adjustments. Enter the DCN (document control number) of the original claim	Conditional REQUIRED for resubmissions or adjustments. Enter the DCN (document control number) of the original claim
38	Responsible party name and address	N/A	Not required
39-41 a-d	Value codes and amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	Conditional REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
42 Lines 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
42 Line 23	Rev CD	Enter 0001 for total charges.	Required
43 Lines 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	Required
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim)	Conditional - Enter the number of pages. (Limited to 4 pages per claim)
44 lines 1-22	HCPCS/Rates	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/ HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed

Field number	Field description	Instruction or comments	Required, conditional or not required
		HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract	
45 Lines 1-22	Service date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	Conditional REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
45 Line 23	Creation date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	Required
46 lines 1-22	Service units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
47 Lines 1-22	Total charges	Enter the total charge for each service line	Required
47 Line 23	Totals	Enter the total charges for all service lines	Required
48 Lines 1-22	Non-covered charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts	Conditional - Enter the noncovered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts
48 Line 23	Totals	Enter the total non-covered charges for all service lines	Conditional - Enter the total noncovered charges for all service lines
49	Unlabeled field	Not used	Not required
50 A-C	Payer	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	Required
51 A-C	Health plan identification number	N/A	Not required
52 A-C	REL information	REQUIRED for each line (A, B, C) completed in field 50.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'	
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services	Required
54	Prior payments	Enter the amount received from the primary payer on the appropriate line	Conditional - Enter the amount received from the primary payer on the appropriate line when Health Net is listed as secondary or tertiary
55	EST amount due	N/A	Not required
56	National Provider Identifier or provider ID	REQUIRED: Enter providers 10-character NPI ID	Required
57	Other provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
58	Insured's name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial	Required
59	Patient relationship	N/A	Not required
60	Insured unique ID	REQUIRED: Enter the patient's insurance ID exactly as it appears on the patient's ID card. Enter the insurance ID in the order of liability listed in field 50	Required
61	Group name	N/A	Not required
62	Insurance group no.	N/A	Not required
63	Treatment authorization code	Enter the prior authorization or referral when services require precertification	Conditional - Enter the prior authorization or referral when services require precertification
64	Document control number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding

Field number	Field description	Instruction or comments	Required, conditional or not required
		on the corresponding A, B, C line Applies to claim submitted with a type of bill (field 4), frequency of "7" (replacement of prior claim) or type of bill, frequency of "8" (void/cancel of prior claim). *Please refer to the reconsider/corrected claims section	A, B, C line reflecting Payer from field 50
65	Employer name	N/A	Not required
66	DX version qualifier	N/A	Required
67	Principal diagnosis code	Enter the principal/ primary diagnosis or condition using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service	Required
67 A-Q	Other diagnosis code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/ update of ICD-10CM	Conditional - Enter additional diagnosis or conditions that coexist at the time of admission

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied	
70	Patient reason code	Enter the ICD-10-CM code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest digit - 4th or 5th. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied	Required
71	PPS/DRG code	N/A	Not required
72 a, b, c	External cause code	N/A	Not required
73	Unlabeled field	N/A	Not required
74	Principal procedure code/date	CODE: Enter the ICD-10 procedure code that identifies the	Conditional - Enter the ICD-10 procedure code that identifies the

Field number	Field description	Instruction or comments	Required, conditional or not required
		principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY)
74 a-e	Other procedure code date	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 procedure codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	Conditional REQUIRED on inpatient claims when a procedure is performed during the date span of the bill
75	Unlabeled field	N/A	Not required

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		• (Blank Field): Enter one of the following provider type qualifiers: • DN - Referring provider. • ZZ - Other operating MD. • 82 - Rendering provider. • NPI: Enter the other physician 10-character NPI ID. • QUAL: Enter one of the following qualifier and ID number, or 0B - State license number • 1G - Provider UPIN number • G2 - Provider commercial number	
80	Remarks	N/A	Not required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	Required
82	Attending Physician	Enter name or seven-digit provider number of ordering physician	Required

Workers' Compensation

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

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

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

Capitated Claims Billing Information

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

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

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

Capitated Risk Claims

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

Electronically Submitted Claims

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

EOC 300/308 Report

Denied Claims

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

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

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

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

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

Field Descriptions

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

Header Information

#	Field	Description
1.	ABS	Health Net's operating system
2.	Program ID	Health Net's assigned number for the report
4.	Claim Type	Facility = UB-04 form Professional = CMS-1500 form
4.	Report Title	The name of the report

#	Field	Description
5.	Run Date	The day/month/year that the report was generated
6.	Run Time	The time that the report was generated
7.	Page Number	The page number of the report
8.	Remit Num	A 14-digit internal number that gives information about the claim's financial status
9.	Check Date	The date of the check issued to a provider for claim payment
10.	Servicing Provider	The TIN and name of the provider who submitted the claim to Health Net for payment
11.	Pay To	The name of the group that the Servicing Provider is linked to. The Servicing Provider and Pay To can be the same

Detail Information

#	Field	Description
12.	Capped PPG/HOSP/PHONE	If a claim was denied on the explanation of check (EOC), then the name of the PPG or hospital where the claim was sent for processing would be listed here with the most current phone number that Health Net has on file
13.	Member ID	Health Net's member identification number

#	Field	Description
14.	MBR Last Name	The last name of the member
15.	MBR First Name	The first name of the member
16.	Claim Number	Health Net's 11-digit Document Control Number (DCN)
17	Beg DOS	The starting date of facility/ professional services
18	End DOS	The ending date of facility/ professional services
19.	PROC	The billed procedure code on the UB-04 or CMS-1500 claim (if services billed are revenue, this field is blank)
20.	DIAG	A three to seven character code based on the ICD-10 coding system, indicating the condition for which services on this claim were rendered
21.	EOC	A three-digit code appears on the provider's EOC explaining the action taken on this claim line. If a claim is coded with EOC 300 or 308, then the claim was denied to responsible capitated PPG or capitated facility for services rendered 300 = Service capitated to member's PPG, claim sent to PPG 308 = Service capitated to facility, claim sent for processing

#	Field	Description
22.	Billed Amt	The amount billed for a claim line

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

Plan-Risk or Shared-Risk Claims

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

The following information must be included on every claim:

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

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

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

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

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

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

For more information, select any subject below:

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

Anesthesia Procedure Code Modifiers with the Minute Qualifier

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

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

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

Use the MJ qualifier with these modifiers:

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

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

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

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.

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

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:

- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.

- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

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

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

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

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

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

Claims Submission and Processing

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

Provider Notification

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

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

Professional Claim Editing

Physicians

Health Net has a contractual relationship with Cotiviti to provide a technology solution for professional claim edit policy management. Using Cotiviti's services, Health Net has the ability to apply advanced contextual

processing for application of Health Net edit logic. Health Net also uses another editing vendor, Verscend, to perform a secondary review after Cotiviti.

The process is as follows:

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

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

Refunds

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

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

Select any subject below:

- Overpayment Procedures

Overpayment Procedures

Provider Type: Physicians | 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

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

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, 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

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:
  - Patient information form and/or member identification (ID) card presented by the Health Net member.
  - Explanation of benefit (EOB) from incorrect carrier and/or participating physician group (PPG).
  - The provider has followed Health Net instructions.
  - Circumstances existed that the provider could not foresee or prevent.
- The length of the delay was such that it was unreasonably difficult or impossible for the provider, in the normal course of business, to file the claim in a timely manner.
- The delay was not the result of the provider's negligent or willful action or inaction.

Other Adjustments Guidelines

For providers who can show proof of claim timely filing, Health Net gives consideration to other provider claim adjustments. The other adjustment policy guidelines are as follows:

- The provider submits proof in the form of one of the following:
  - Electronic data interchange (EDI) confirmation that Health Net received and accepted the claim.
  - Delivery confirmation evidence (for example, registered receipt or certified mail receipt to a Health Net address).
  - Screen print from accounting software to show the date the claim was submitted.

When Medicare is a Secondary Payer

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

Health Net works to coordinate member benefits with identified third-party payers, which may include private and government insurance plans. Medicare is generally the primary payer for a member unless the member's current situation dictates his or her private insurance plan is primary to Medicare, such as when the member is actively employed and covered by an employer group benefit plan. In such cases, and when Medicare has previously paid for services as the primary carrier, Medicare issues a Medicare secondary payer (MSP) recovery demand letter. The demand letter includes the participating provider liability claims and claims details and requests a refund from the employer directly and Health Net indirectly as the employer's designated health plan.

If Health Net determines that the MSP recovery demand contains provider liability claims, Health Net sends the provider's MSP contact a demand letter with detailed instructions for responding to the demand, a spreadsheet listing the claims, and a copy of all claims that require provider intervention. (Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Manuals 100-05 Chapters 1-4)

Providers who have questions, contact the Health Net Provider Services Center or the Medicare Provider Services Center.

Claims Coding Policies

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

This section describes Health Net's claims coding process and policies.

Select any subject below:

- Code Editing

Code Editing

Provider Type: Physicians

The plan uses Health Insurance Portability and Accountability Act (HIPAA)-compliant clinical claims editing software for physician and outpatient facility coding verification. The software detects, corrects and documents coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding rule. When the software identifies a claim that does

not adhere to a coding rule, a recommendation known as an edit is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, the plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify circumstances where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, the plan may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

Current Procedural Terminology (CPT) codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. CPT codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. Level I HCPCS Codes (CPT): This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.
2. Level II HCPCS: The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by Centers for Medicare and Medicaid Services (CMS). Level II HCPCS codes are updated on an annual basis.
3. Miscellaneous/Unlisted Codes: The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing unlisted codes must submit medical documentation that clearly defines the procedure performed, including, but not limited to, office notes, operative report, pathology report, and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the unlisted code. For example, if the unlisted code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.
4. Temporary National Codes: These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered

temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. HCPCS Code Modifiers: Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management (E/M) services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10) Code Set

These codes represent classifications of diseases and related health problems. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes indicate the type of procedure performed on patients and where the service was performed. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims auditing software contains a comprehensive set of rules addressing coding inaccuracies, such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research, etc.

The software applies edits that are based on the following sources.

- CMS, National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include Column one/Column two, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control improper coding leading to inappropriate payment.
- Public domain specialty society guidance (such as, American College of Surgeons, American College of Radiology, and American Academy of Orthopedic Surgeons).
- Medicare Claims Processing Manual.
- NCCI Policy Manual for Medicare Services.
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals).
- CMS coding resources, such as, HCPCS Coding Manual, Medicare Physician Fee Schedule (MPFS), Provider Benefit Manual, MLN Matters and Provider Transmittals.
- AMA resources:
    - CPT Manual
    - AMA Website
    - Principles of CPT Coding

- Coding with Modifiers
- CPT Assistant
- CPT Insider's View
- CPT Assistant Archives
- CPT Procedural Code Definitions
- HCPCS Procedural Code Definitions

- Billing Guidelines Published by Specialty Provider Associations:
  - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims.
- Health plan policies and provider contract considerations.

Code Editing and the Claims Adjudication Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

- Deny: Code editing recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Replace and Pay: Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of the available code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

NCCI Procedure-to Procedure (PTP) Practitioner and Hospital Edits

CMS National Correct Coding Initiative (NCCI) - refer to the CMS website at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. CMS has designated certain combinations of codes that should never be billed together, which are known as PTP or Column one/Column two edits. The column one procedure code is the most comprehensive code and reimbursement for the column two code is subsumed into the payment for the comprehensive code. The column two code is considered an integral component of the column one code.

The CMS NCCI edits consist of PTP edits for physicians and hospitals. Practitioner PTP edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). Hospital PTP edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers, and comprehensive outpatient rehabilitation facilities. While PTP code pairs should not typically be billed together, there are circumstances when an NCCI-associated modifier may be appended to the column two code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

NCCI

MUE for Practitioners, DME Providers and Facilities

The purpose of the NCCI MUE program is to prevent improper payment when services are reported with incorrect units of service. MUEs reflect the maximum units of service that a provider would bill under most circumstances for a single member, on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information, and clinical judgment.

Code Bundling Rules Not Sourced To CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations in which the less comprehensive procedure is considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Evaluation and Management (E/M) Service Editing

CMS publishes rules surrounding payment of an E/M service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0-, 10- or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

E&M services for a major procedure (90-day global period) that are reported one-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

E&M services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

E/M services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing Procedures with MMM

Global periods for maternity services are classified as MMM in the Medicare Physician Fee Schedule (MPFS). E&M services billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered to be bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes billing of two or more procedure codes when a single more comprehensive code should have been billed to accurately represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. A frequency edit will be applied by code auditing software when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example a nurse practitioner and physician billing for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under the health plan. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon per CMS and American College of Surgeons (ACS) guidelines. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS and ACS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

Identifies claims with an add-on CPT code billed without the primary service CPT code. Additionally, if the primary service code is denied, then the add-on code is also denied. This rule also looks for circumstances in which the primary code was billed in a quantity greater than one when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the provider bills several lab tests separately that are included as part of a more comprehensive code. This rule will deny the individual lab test codes and add a service line with the appropriate comprehensive code. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician. In some instances, the original service line will be denied and a new service line added with the appropriate modifier. This does not change the original billing, as the original service line remains on the claim.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are

not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes.
- Deleted Codes: Evaluates claims for procedure codes which have been deleted.
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.
- Age Rules: Identifies procedures inconsistent with member's age.
- Gender Procedure: Identifies procedures inconsistent with member's gender.
- Gender Diagnosis: Identifies diagnosis codes inconsistent with member's gender.
- Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid.

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of clinical validation services is the review of modifiers -25 and -59. Code pairs within the CMS NCCI edit tables with a modifier indicator of "1" allow for a modifier to be used in appropriate circumstances to allow payment for both codes. Furthermore, public domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). MA's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

CMS supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier -59

NCCI states the primary purpose of modifier -59 is to indicate that procedures or non-editing/medical services that are not usually reported together are appropriate under the circumstances. The CPT manual defines modifier -59 as distinct procedural service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other nonservices performed on the same day. Modifier -59 is used to identify procedures/services, other than editing/medical services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or

separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier -59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier -59 related to the portion of the definition that allows its use to describe different procedure or surgery. NCCI guidelines state that providers should not use modifier -59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier -59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

The plan uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier -59 were used appropriately.
- To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS, in the NCCI policy manual, specify that by using a modifier -25 the provider is indicating that a significant, separately identifiable E&M service was provided by the same physician on the same day of the procedure or other service. Additional CPT guidelines state that the E&M service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that if a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000). The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare carriers and A/B Medicare administrative contractor (MAC) processing practitioner service claims have separate edits.

The plan uses the following guidelines to determine whether -25 was used appropriately. If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E&M service.

- The E&M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed.

- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services.
- Other procedures or services performed for a member on or around the same date of the procedure support that an E&M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E&M services.

Claim Reconsiderations Related To Code Editing

Claims appeals resulting from claim editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code edit or edit and request claim reconsideration, you must submit medical documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit or edit will be upheld.

Viewing Claims Coding Edits

Code Editing Assistant

The Code Editing Assistant is a Web-based code editing reference tool designed to mirror how the code editing product(s) evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking Claim Editing Tool in our secure provider portal.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- Proactively determines the appropriate code or code combination representing the service for accurate billing purposes.

The tool will review what was entered, and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.The Code Editing Assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan's provider portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.XX in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.XX in the reference number of the policy.

The majority of clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex code can be viewed on the provider's explanation of payment.

- xE: Procedure Code is Disallowed with this Diagnosis Code(s) Per Plan Policy.

Examples

Policy Name	Clinical Policy Number	Description
Diagnosis of Vaginitis	CP.MP.97	To define medical necessity criteria for the diagnostic evaluation of vaginitis in members ages 13 or older.
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies.
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

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

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

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

Clinical Payment Policy Appeals

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

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

Compliance and Regulations

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

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

Select any subject below:

Mandatory Data Sharing Agreement

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

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

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

Participating entities that must sign a DSA include:

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

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

Reproductive Privacy Act

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

Reproductive rights, privacy and the exchange of information

Certain businesses handling medical information on sensitive services must develop security policies for data related to gender-affirming care, abortion, abortion-related services, and contraception. California law also prohibits health care providers, plans, contractors, or employers from sharing medical information for

investigations or inquiries from other states or federal agencies regarding lawful abortions unless authorized by existing law.

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

State law specifically states:[1]

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

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

- **Legally protected health care activity** includes, but is not limited to:
  - Reproductive health care services,
  - Gender-affirming health care services, and
  - Gender-affirming mental health care services.

- **Sensitive services** include, but are not limited to:
  - Services related to mental/behavioral health,
  - Sexual and reproductive health,
  - Sexually transmitted infections,
  - Substance use disorder,
  - Gender affirming care, and
  - Intimate partner violence.

Requirements for providers

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

- Specified businesses that store or maintain medical information regarding sensitive services must develop specific policies, procedures and capabilities that protects sensitive information.

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

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

Provider Offshore Subcontracting Attestation

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

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

An example of an offshore subcontracting relationship is a physician, laboratory, medical group, or hospital contracting with an entity to process claims, and that entity uses resources that are not located in the United States to process the provider's claims. The provider is responsible to have processes in place that protect members' PHI.

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

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

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

- A policy and procedure that documents the process used for conducting annual audits, regular monitoring and tracking results, and resolving any identified deficiencies.

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

Communicable Diseases Reporting

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

To protect the public from the spread of infectious, contagious and communicable diseases, every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, are required by law to notify the local health department (LHD). A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

The term health care provider includes physicians and surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, and dentists.

Notification

Providers must report cases of communicable diseases using the Confidential Morbidity Report (PDF) . They must send a completed copy of the report to the Communicable Disease Control division of the County Health Department. The time frame for reporting suspected cases of communicable diseases varies according to disease and ranges from immediate reporting by telephone or fax to seven days by mail.

The notification must include the following, if known:

- Name of the disease or condition being reported
- Date of onset
- Date of diagnosis
- Name, address, telephone number, occupation, race or ethnic group, Social Security number (SSN), age, sex, and date of birth for the case or suspected case
- Date of death, if death has occurred
- Name, address and telephone number of the person making the report

HIV Reporting Requirements for Laboratories

The following document applies only to Ancillary providers.

HIV is a reportable disease under California state law. Laboratories are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer for the

local jurisdiction where the health care provider is located and the requesting provider within seven calendar days.

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

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

Laboratories may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail. Laboratories should contact the local county health department for information and reporting forms.

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

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

  Testing laboratories generate a report that consists of the following information:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Name, address and telephone number of the health care provider and the facility that submitted the biological specimen to the laboratory, if different
- Name, address the telephone number of the laboratory
- Laboratory report number as assigned by the laboratory
- Laboratory results of the test performed
- Date biological specimen was tested in the laboratory
- Laboratory Clinical Laboratory Improvement Amendment (CLIA) number

Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing site, other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

HIV Reporting Requirement for Providers

HIV is a reportable disease under California state law. Health care providers are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer within seven calendar days.

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

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

- Courier service, U.S. Postal Service Express, or registered mail or other traceable mail

- Person-to-person transfer with the local health officer or their designee

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

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

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

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

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

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

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

Reporting Requirements for Hepatitis and Sexually Transmitted Infections

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

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

Tuberculosis Reporting and Care Management

Tuberculosis (TB) reporting is done immediately by telephone or fax to expedite the process. The Confidential Morbidity Report form (PDF) should be used to notify the local health department's Communicable Disease Reporting Divisions. When reporting a case of TB, the health care provider must provide information on the diagnostic status of the case or suspected case; bacteriological, radiological and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons; and a list of the anti-tuberculosis medications administered to the member. In addition, a report must be made any time a person ceases treatment for TB, including when the member fails to keep an appointment, relocates without transferring care, or discontinues care. Further, the local health officer may require additional reports from the health care provider.

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

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

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

Tuberculosis Care Management

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

Federal Lobbying Restrictions

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

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

- File a declaration with the plan Net certifying that no inappropriate use of federal funds has occurred or will occur (use Certification for Contracts, Grants, Loans, and Cooperative Agreements Form (PDF)). This extends to any subcontract a participating provider may have that exceeds $100,000 in value. In these cases, the participating provider is required to collect and retain these declarations

- File a specific disclosure form if non-federal funds have been used for lobbying purposes in connection with any line of business (use Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF))
- File quarterly updates, such as a disclosure form at the end of any calendar quarter in which disclosure is required or in which an event occurs that materially affects the previously filed disclosure form

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

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

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

Health Net Affiliates

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

Below is a listing of Health Net's affiliates. Health Net affiliates generally may opt to periodically access the *Provider Participation Agreement* (*PPA*) for covered services delivered by providers under those benefit programs in which providers participate.

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

Material Change Notification

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

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

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

Nondiscrimination

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

The following nondiscrimination requirements apply.

Employment

The plan and its participating providers must comply with the provisions of the Fair Employment and Housing Act (FEHA) (California Government Code, Section 12900 and following) and the regulations set forth in the California Code of Regulations, Title 2, Chapter 2, commencing with Section 7286.0 and following. The plan and its participating providers may not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. In addition, the plan and its participating providers ensure the following:

- Evaluation and treatment of employees and applicants for employment is free of such discrimination
- Written notice of obligations under this clause is given to labor organizations with which the plan or its participating providers have a collective bargaining or other agreement

Health Programs and Activities

The following requirements apply[1, 2]:

- Participating providers must add plan-specific nondiscrimination notices and taglines in significant publications and communications issued to members.To obtain additional information refer to Industry Collaboration Effort (ICE) website. If you are not able to locate specific notices or taglines, contact the Delegation Oversight Department.

- If necessary, participating providers must assess and enhance existing policies and procedures to ensure effective communication with members.
- Participating providers must ensure programs or activities provided through electronic or information technology, such as websites or online versions of materials, are accessible to individuals with disabilities. If necessary, participating providers must assess and enhance website compliance with Title II of the ADA.
- Participating providers must notify the plan immediately of a discrimination grievance submitted by a member and continue to follow the plan's existing issue write-up procedures for detection and remediation of non-compliance. Additionally, participating providers must comply with the plan, regulatory or private litigation research, investigations, and remediation requirements.
- Participating providers must assess and enhance, if necessary, existing language assistance services to ensure they are compliant.
- Participating providers must implement, enhance and reinforce prohibitions on exclusions, denials or discrimination such as in design, operation or behavior of benefits or services on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. Additionally, they must implement, where applicable:
    - Medical necessity reviews for all gender transition services and surgery.
    - Program or activity changes to avoid discrimination where necessary.
    - Plan design changes where necessary, such as removing categorical gender or age exclusions.
    - Additionally, providers must remove prohibited categorical exclusions and denial reasons, and update nondiscrimination policies and procedures to include prohibitions against discrimination on the basis of sex, including gender identity and sex stereotyping.
- Participating providers can consider implementing the following:
    - Ability to capture gender identity.
    - Mandatory provider and staff civil rights and/or cultural sensitivity training.

[1] For Medicare Advantage and Commercial products: In addition to the State of California nondiscrimination requirements and in accordance with Section 1557, 45 CFR Part 92 of the Affordable Care Act of 2010 (ACA).

[2] For Medi-Cal and Dual Special Need Plans: In addition to the State of California nondiscrimination requirements, and in accordance with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 including sections 504 and 508, as amended; Titles I, II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes.

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 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

Overview

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

Coordination of benefits (COB) allows group health plans to eliminate the opportunity for a person to profit from an illness or injury as the result of duplicate group health plan coverage. Generally, one plan is determined to

be primary, and that plan pays without regard to the other. The secondary plan then makes only a supplemental payment that results in a total payment of not more than the eligible expenses for the medical service provided.

If one plan is an individual plan, not a group plan, both plans pay as primary. The payments do not coordinate.

Participating providers are required to administer COB when such provisions are a requirement of the benefit plans. The participating provider should ask the member for possible coverage through any other group or individual insurance or HMO plan and enter the other health insurance information on the claim.

Contact the Provider Services Department with any information identifying COB coverage for a member.

COB Payment Calculations

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

As the secondary carrier, the plan coordinates benefits and pays balances, up to the member's liability, for covered services, unless the maximum allowable is paid by the primary care insurer. However, the dollar value of the balance payment cannot exceed the dollar value of the maximum allowable amount that would have been paid had the plan been the primary carrier.

In most cases, members who have coverage through two carriers are not responsible for cost shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member. Copayments are waived when a member has other insurance as primary coverage. If a participating provider contracts with two HMOs and the member belongs to both, all prior authorization requirements for both carriers must be complied with in order to coordinate benefits. For example, if the primary carrier as well as the plan require authorization for a procedure or service, and authorization is requested and approved by the primary carrier, the plan does not require authorization for that procedure or service. However, if the primary carrier requires authorization and authorization is not requested or approved from the primary carrier, and the plan requires authorization, the plan does not make payment as the secondary carrier unless the prior authorization is requested and approved by the plan

Disagreements with Other Insurers

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

Not all insurers operate under the jurisdiction of the California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI). In some instances, insurers do not operate under any legal authority at all regarding coordination of benefits (COB). For this reason, hospitals may encounter insurers, administrators and others who would ordinarily be the primary carrier but refuse to pay. There is no practical recourse if they have different rules in their state or are a self-funded plan.

When disagreements arise with insurers due to differences in applicable law, abides by the rules employed by the state in which the other insurer operates. For self-funded plans, the plan abides by the conditions in the self-funded plan's evidence of coverage. After dealing with the immediate matter of providing or paying for a covered service, the hospital can still make an effort to recover payment from the other insurer.

The Plan's Right to Pay Others

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

A payment made by another health plan may include an amount that should have been paid by the plan. If this happens, the plan may pay the amount to the organization that made the payment. The amount is then treated as though paid under the member's coverage. The plan does not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

When the Plan is the Primary Carrier

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

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

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

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

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

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

When the Plan is the Secondary Carrier

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

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

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

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

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

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

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

Copayments

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

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

Select any subject below:

- 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 x 20% = $800).

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 31st 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

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

Practitioners or organizational providers subject to credentialing or recredentialing and contracting directly with the plan must submit a completed plan-approved application. By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes the plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review.
- Releases the plan and its independent contractors, agents and employees from any liability connected with the credentialing review.

Approval, Denial or Termination of Credentialing Status

The Credentialing Committee or physician designee reviews rosters of delegated and non-delegated practitioners and organizational providers meeting all plan criteria and approves their admittance or continued participation in the network.

A peer review process is used for practitioners with a history of adverse actions, member complaints, negative quality improvement (QI) activities, impaired health, substance abuse, health care fraud and abuse, criminal history, or similar conditions to determine whether a practitioner should be admitted or retained as a participant in the network.

Practitioners are notified within 60 calendar days of all decisions regarding approval, denial, limitation, suspension, or termination of credentialing status consistent with the health plan, state and federal regulatory requirements and accrediting entity standards. This notice includes information regarding the reason for denial determination. If the denial or termination is based on health status, quality of care or disciplinary action, the practitioner is afforded applicable appeal rights. Practitioners who have been administratively denied are eligible to reapply for network participation as soon as the administrative matter is resolved.

Failure to respond to recredentialing requests may result in the practitioner's administrative termination from the network.

Appeals

Practitioners, whose participation in the plan's network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons, are provided notice and an opportunity to appeal. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from, the network.

The notice of altered participation status will be provided in writing to the affected practitioner and include:

- The action proposed against the practitioner by the Credentialing or Peer Review committee.
- The reason for the action.
- The plan policies or guidelines that led to the committee's adverse determination.
- Detailed instructions on how to file an appeal (informal reconsideration or formal hearing).

A practitioner may choose to engage in an informal appeal and provide additional information for the Credentialing Committee's consideration or move directly to a formal fair hearing. Affected practitioners who are not successful in overturning the original committee decision during an informal reconsideration are automatically afforded a fair hearing, upon request in writing within 30 days from the date of notice of the denial.

A practitioner must request a reconsideration or fair hearing in writing. The plan's response to the request will include:

- Dates, times and location of the reconsideration or hearing.
- Rules that govern the applicable proceedings.
- A list of practitioners and specialties of the committee or fair hearing panel.

The composition of the fair hearing panel must include a majority of individuals who are peers of the affected practitioner. A peer is an appropriately trained and licensed physician in a practice similar to that of the affected practitioner.

Affected practitioners whose original determinations are overturned are granted admittance or continued participation in the plan's network. The decision is forwarded to the affected practitioner in writing within 14 calendar days of the fair hearing panel's decision.

Affected practitioners whose original determinations have been upheld are given formal notice of this decision within 14 days of the fair hearing panel's ruling. The actions are reported to the applicable state licensing board and to the National Practitioner Data Bank (NPDB) within 14 days of the hearing panel's final decision.

Practitioners who have been denied or terminated for quality-of-care concerns must wait a minimum of five years from the date the adverse decision is final in order to reapply for network participation. At the time of the reapplication, the practitioner must:

- Meet all applicable plan requirements and standards for network participation.
- Submit, at the request of the committee or Credentialing Department, additional information that may be required to confirm the earlier adverse action no longer exists.
- Fulfill, according to applicable current credentialing policies and procedures, all administrative credentialing requirements of the plan's credentialing program.

Credentialing Responsibility, Oversight and Delegation

The plan may delegate to individual practitioners, participating physician groups (PPGs) or other entities responsibility for credentialing and recredentialing activities. Credentialing procedures used by these entities may vary from plan procedures, but must be consistent with the health plan, state and federal regulatory requirements and accrediting entity standards.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the oversight of delegated activities must meet or exceed plan standards. The plan oversees delegated responsibilities on an ongoing basis through an annual audit and semiannual, or more frequent, review of delegated PPG-specific data.

The plan can revoke the delegation of any or all credentialing activities if the delegated PPG or entity is deemed noncompliant with established credentialing standards. The plan retains the right, based on quality issues, to terminate or restrict the practice of individual practitioners, providers and sites, regardless of the credentialing delegation status of the PPG.

Each delegated practitioner or provider losing delegated credentialing status must complete the plan's initial credentialing process within six months.

Hiring Non-Participating Providers

The following document applies only to Physicians and Participating Physician Groups (PPG).

In an effort to comply with applicable federal and state laws and regulations, all participating providers in the plan's network must comply with the following standards when hiring a non-participating provider to provide services to plan members. Participating providers must be able to demonstrate that each non-participating provider has supporting documentation that includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable.
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Malpractice insurance coverage that meet these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- Absent of any sanctions that would not allow them to see a Medicare member.

Additionally, the practitioner must be absent from:

- The Medicare Opt Out report if treating Medicare members.
- The Office of the Inspector General's (OIG) sanctions list of individuals and entities (LEIE) if treating Medicaid and Medicare members.
- The System for Award Management's Exclusions Extract Data Package (EEDP) if treating Medicare members.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.

The plan's participating providers are responsible for ongoing monitoring of sanctions and validating licensing. All participating providers are required to comply with applicable federal, state and local laws and regulations as well as the policies and procedures as outlined in the Provider Participation Agreement (PPA).

Investigations

The plan investigates adverse activities indicated in a practitioner or provider's initial credentialing or recredentialing application materials or identified between credentialing cycles. The plan may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. Health Net may require a practitioner or provider to supply additional information regarding any such adverse activities. Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board.
- Current or past chemical dependency or substance abuse.
- Health care fraud or abuse.
- Member complaints.
- Substantiated quality of care concerns activities.
- Impaired health.
- Criminal history.
- Office of Inspector General (OIG) Medicare/Medicaid sanctions.
- Federal Employees Health Benefits Program (FEHBP) debarment.
- System Award Management (SAM), inclusive of Excluded Parties List System (EPLS), EEDP.
- The Medi-Cal Suspended and Ineligible Provider listing.
- Substantiated media events.
- Trended data.

At the plan's request, a practitioner or provider must assist the plan in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within the prescribed time frames.

Organizational Providers Certification or Recertification

An organizational provider (OP) is an institutional provider of health care that is licensed by the state or otherwise authorized to operate as a health care facility. Examples of OPs include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and ambulatory surgical centers (ASCs).

Organizational providers that require assessments by the plan or its delegated entities include:

- Hospitals

- Home health agencies
- Hospices
- Clinical laboratories *(accreditation is mandatory)*
- Skilled nursing facilities
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy, occupational therapy and speech pathology providers
- Ambulatory psychiatric and addiction disorder facilities and clinics
- Psychiatric and addiction disorder residential treatment facilities
- Twenty-four-hour behavioral healthcare units in general hospitals
- Substance abuse treatment facilities
- Other freestanding psychiatric hospitals and treatment facilities
- Ambulatory surgery centers
- Providers of end stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable x-ray suppliers

- Rural health centers (RHCs), federally qualified health centers (FQHCs) and Indian Health Centers (IHCs)*
- Sleep study centers (as applicable)
- Radiology/imaging centers (as applicable)
- Urgent care facilities (as applicable)
- Community Based Adult Services (CBAS)
- Free Standing and Alternative Birthing Centers
- Telehealth/Telemedicine Services Provider*
- Intermediate Care Facility

CalAIM - Community Supports Provider/In Lieu of Services Provider.**

Non-Traditional providers are not certified or credentialed. They require vetting to ensure acceptance into our network. Of note; if a traditional Provider, Hospital, Ancillary, PPG or Practitioner oversee the non-traditional providers, the Provider is responsible to ensure they meet the needs to join our network.

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Community Transition Services/Nursing
- Facility Transition to a Home
- Personal Care and Homemaker Services
- Sobering Centers
- Environmental Accessibility Adaptions (Home Modifications)
- Meals/Medically Tailored Meals or Medically Supportive Foods
- Asthma Remediation
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF)

CalAIM – Enhanced Care Management Provider**

Community Health Worker - Provider**

*The facility is exempt from the certification process if the individual practitioners within this clinic are individually contracted/credentialed.

** Non-Traditional Care Facilities are required to submit a vetting attestation only.

Is licensed to operate in the state and is following any other applicable federal or state requirements.

Providers contracting directly with the plan must submit a completed, signed plan-approved hospital or ancillary facility credentialing application and any supporting documentation to the plan for processing. The documentation, at a minimum, includes:

- Evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an on-site survey prior to being issued a state license. Accepted agency surveys include those performed by the state Department of Health and Human Services (DHHS), Department of Public Health (DPH) or Centers for Medicare & Medicaid Services (CMS).

- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess a current city license, fictitious name permit, certificate of need, or business registration.
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent DHHS/DPH site survey as described above is required. A favorable site review consists of compliance with quality-of-care standards established by CMS or the applicable state health department. The plan obtains a copy of each surgery center's site survey report and ensures each provider has received a favorable rating. This may include a completed corrective action plan (CAP) and DHHS CAP acceptance letter.
- Professional and general liability insurance coverage that meets plan requirements.
- Overview of the facility's quality assurance/quality improvement program upon request.

Organizational providers are recredentialed at least every 36 months to ensure each entity has continued to maintain prescribed eligibility requirements.

Practitioner's Rights

Right of Review Request for Current Network Status

A practitioner has the right to review information obtained by the plan for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (for example, malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to the credentialing manager or supervisor. The credentialing manager or supervisor notifies the practitioner within 72 hours of the date and time when such information is available for review at the Credentialing Department. Upon written request, the Credentialing Department provides details of the practitioner's current status in the initial credentialing or recredentialing process.

Notification of Discrepancy

Practitioners are notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board-certification expiration when one or more of these examples have not been self-reported by the practitioner on their application. Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

A practitioner who believes that erroneous information has been supplied to the plan by primary sources may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed explanation, to the Credentialing Department manager or supervisor. Notification to the plan must occur within 48 hours of the plan's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of their credentials file. Upon receipt of notification from the practitioner, the plan re-verifies the primary source information in dispute. If the primary source information has changed, a correction is made immediately to the practitioner's credentials file. The

practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to the Credentialing Department via letter or fax within 10 business days. The Credentialing Department re-verifies primary source information if such documentation is provided. If after 10 business days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.

Primary Source Verification for Credentialing and Recredentialing

The Credentialing Department obtains and reviews information on a credentialing or re-credentialing application and verifies the information in accordance with the primary source verification practices. The plan requires participating physician groups (PPGs) to which credentialing has been delegated to obtain primary source information (outlined below)* in accordance with the standards of participation, state and federal regulatory requirements, and accrediting entity standards.

*Primary Source Verification

- Medical doctors (MD)
- Nurse Practitioners (NP)
- Oral surgeons (DDS/DMD)
- Chiropractors (DC)
- Osteopaths (DO)
- Podiatrists (DPM)
- Mid-level practitioners (non-physicians)
- Acupuncturist

Recredentialing for Practitioners

The plan's credentialing program establishes criteria for evaluating continuing participating practitioners. This evaluation, which includes applicable primary source verifications, is conducted in accordance with the health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners meeting and maintaining the standards for participation requirements are retained in the network.

Practitioners due for recredentialing must complete all items on an approved plan application and supply supporting documentation, if required. Documentation includes, but is not limited to:

- Current state medical license.
- Attestation to the ability to provide care to members without restriction.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate or Chemical Dependency Services (CDS) certificate, if applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state.

- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one participating hospital or surgery center, or a documented coverage arrangement with a credentialed or participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- Trended assessment of practitioner's member complaints, quality of care, and performance indicators.

Standards of Participation

All practitioners participating in the plan's network must comply with the following standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing and practitioners due for recredentialing must complete all items on an approved credentialing application and supply supporting documentation, if required. The verification time limit for a plan approved application is 180 days. Applications are available at the Council of Affordable Quality Healthcare (CAQH) website at www.caqh.org for the Universal Credentialing DataSource link. Supporting documentation includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable. The DEA and/or CDS registration must be issued in the state(s) in which the practitioner is contracting to provide care to the members.
- Continuous work history for the previous five years with a written explanation of any gaps of a prescribed time frame (initial credentialing only).
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Evidence of active admitting privileges in good standing, with no reduction, limitation, or restriction on privileges, with at least one participating hospital or surgery center, contracted hospitalist group or a documented coverage arrangement with a credentialed, participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely.

Additionally, the practitioner must be absent from:

- The Medicare Opt-Out Report if treating members under the Medicare lines of business.
- The Medicare/Medicaid Cumulative Sanction Report if treating members under the Medicare lines of business.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.
- The Excluded Parties List System (EPLS) EEDP through the System for Award Management (SAM) Report.
- The Medi-Cal Suspended and Ineligible Provider listing.

Terminated Contracts and Reassignment of Members

The plan notifies members as required by state law if a practitioner's contract participation status is terminated. The plan oversees reassignment of these members to another participating provider where appropriate.

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.
- 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
- 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 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 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 to view the Denial File Fax Back template located under Approved ICE Documents. An expedient method for this purpose is to complete a Denial File Fax-Back Sample, including the name and telephone number of the physician who denied the service when faxing back the denial information.

Requirements for Notification of Utilization Management Decisions

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

Health Net and its participating physician groups (PPGs) to which utilization management (UM) functions have been delegated are required to comply with timeliness standards for UM decisions and notifications. Health Net has adopted the timeliness standards approved by the Industry Collaboration Effort (ICE) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the ICE website at www.iceforhealth.org/home.asp to locate the Approved ICE Documents for the commercial and Medi-Cal ICE UM Timeliness Standards.

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

Required Responses to Provider Inquiries Regarding Coverage

A qualified beneficiary may take up to 60 days to elect Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage from the day that the COBRA election notice is mailed to the qualified beneficiary or the date of the qualifying event, whichever is later. During this election period, a qualified

beneficiary may seek health services. Participating providers following eligibility verification procedures may contact the plan to determine if the qualified beneficiary has coverage.

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

Election Period Requirements

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

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

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

Complete Responses During an Election Period

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

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

- The individual is a COBRA-qualified beneficiary with the right to elect and pay for continued coverage.
- The individual's coverage is subject to retroactive termination if the COBRA premium payment is not made.

- If the election and payment are made on time, coverage is reinstated retroactively to the date of the qualifying event (or loss of coverage date, if different)

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

Grace Period Requirements

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

Complete Responses During a Grace Period

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

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:

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:

- 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 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:

- 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.

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

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.

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

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.

Medical Records

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

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

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

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

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

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

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

Provision of Medical Records

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

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

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

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

Access to Records and Audits by Health Plan

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

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

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

EMR Access

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

Written Protocols

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

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

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

For more information, select any subject below:

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

Confidentiality of Medical Records

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

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, claims and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. Written authorization from the member or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the health plan.

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

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PHI is considered confidential and encompasses any individual health information, including demographic information collected from a member, which is created or received by Health Net and relates to the past, present or future physical, mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member or there is a reasonable basis to believe the information may be used to identify the member. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written member authorization.

Confidentiality of Medical Information

Sensitive services are defined as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924-6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

Assembly Bill 1184 (2021), amends the Confidentiality of Medical Information Act to require health care plans to take additional steps to protect the confidentiality of a subscriber's or enrollee's medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

These steps include:

- A protected individual (member) is not required to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care.
- Not disclose a member's medical information related to sensitive health care services to the primary subscriber or other enrollees, unless the member's authorization is present.
- Notify the subscriber and enrollees that they may request confidential communications and how to make the request. This information must be provided to "enrollees" at initial enrollment and annually.
- Respond to confidential communications requests within:
    - 7 calendar days of receipt via electronic or phone request or
    - 14 calendar days of receipt by first-class mail
- Communications (written, verbal or electronic) regarding a member's receipt of sensitive services should be directed to the member's designated mailing address, email address, or phone number. For protected individuals who may not have designated an alternative mailing address, the provider and/or Plan is required to send the communications to the address or phone number on file in the name of the protected individual.
- Confidential communication includes:

- Bills and attempts to collect payment.
- A notice of adverse benefits determinations.
- An explanation of benefits notice.
- A plan's request for additional information regarding a claim.
- A notice of a contested claim.
- The name and address of a provider, description of services provided, and other information related to a visit.
- Any written, oral, or electronic communication from a plan that contains protected health information.

Agencies Must Be Authorized To Receive Medical Records

The relationship and communication between a participating provider and member is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and protected health information (PHI), whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

Requirements for a Valid Authorization for Release of Information

Providers must obtain signed authorization from the member to use or disclose the member's medical information. You also need to give instructions to members on how to access additional copies or digital versions of the signed authorization. The signed authorization must:

- Be written in plain language and no smaller than 14-point font.
- Be dated and signed with an electronic or handwritten signature by the member or person authorized to act on behalf of member.
- Specify the type of individuals authorized to disclose information about the member.
- Specify the nature of the information authorized to be disclosed.
- State the name or functions of the persons or entities authorized to receive the information.
- Specify the purposes for which the information is collected.
- Specify the length of time the authorization shall remain valid.
- State an expiration date or event. The expiration date for a valid signature is up to one year unless the person signing the authorization requests a specific date beyond a year, or the authorization is related to an approved clinical trial1 after which the provider, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

Real Time Data Exchange of Health Information

The following entities shall exchange health information or provide access to health information to and from every other of these same entities in real time as specified by the California Health and Human Services

Agency pursuant to the California Health and Human Services Data Exchange Framework data sharing agreement for treatment, payment, or health care operations.

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities that currently maintain electronic records.
- Health care service plans and disability insurers that provide hospital, medical, or surgical coverage that are regulated by the Department of Managed Health Care or the Department of Insurance, and Medi-Cal managed care plans contracted with the State Department of Health Care.
- Clinical laboratories regulated by the State Department of Public Health.
- Acute psychiatric hospitals.

Exceptions

The exchange of health information described above does not apply to:

- Physician practices of fewer than 25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.
- Abortion and abortion-related services.

Basic Principles

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

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

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

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

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

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

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

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

Procedure

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

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

Release of medical information guidelines must address:

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

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

- A specific and meaningful description of the information to be used or disclosed
- The name of the person or entity authorized to make the requested use or disclosure
- The name of a person or entity to which the use or disclosure may be made
- A description of each purpose or use for the information. If the individual requests the authorization for their own purposes, the description here may read simply "at the request of the individual"
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- The signature of the individual and the date
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation
- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization, unless a valid exception applies (such as, pre-enrollment underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule

Medical Record Documentation

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

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

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

For more information, select any subject below:

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

Advance Directives

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

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

Medical Record Documentation Standards

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

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

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

Medical Record Performance Measurements

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

Health Net monitors medical record documentation through a variety of measures, which includes, but is not limited to, various quality initiatives, data collection by way of primary care physician (PCP) medical record audits, and records collected through the Healthcare Effectiveness Data and Information Set (HEDIS®) process. Data is aggregated and analyzed at least annually. Opportunities for improvement are identified and

appropriate interventions are implemented based on compliance levels established for each individual activity. Interventions may include sending providers updates, educational or reference materials, creating template medical record forms, and provider and staff education and training. Participating providers are required to obtain a performance level of at least 80% on the medical record performance measures for a conditional pass.

Medical Record Forms and Aids

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

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

Select any subject below:

- Medical Record Forms and Aids

Medical Record Forms and Aids

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

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

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

Member Rights and Responsibilities

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

This section contains general information on member rights and responsibilities.

Select any subject below:

- Advance Directives
- Member Rights and Responsibilities

Advance Directives

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

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

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

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

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

- The advance directive contains the date of its execution
- The advance directive is signed either by the member or in the member's name by another adult in the member's presence and at the member's direction
- The advance directive is either acknowledged before a notary public or signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675 of the California Probate Code
- If the advance directive is acknowledged before a notary public, and a digital signature is used, the digital signature must meet all of the following requirements:
    - It either meets the requirements of Section 16.5 of the Government Code and Chapter 10 (commencing with Section 22000) of Division 7 of Title 2 of the California Code of Regulations, or the digital signature uses an algorithm approved by the National Institute of Standards and Technology
    - It is unique to the person using it
    - It is capable of verification
    - It is under the sole control of the person using it
    - It is linked to data in such a manner that if the data are changed, the digital signature is invalidated
    - It persists with the document and not by association in separate files
    - It is bound to a digital certificate

For more information, select any subject below:

- Provider Responsibilities and Procedures

Provider Responsibilities and Procedures

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

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

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

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

Member Rights and Responsibilities

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

Members have the right to expect a certain level of service from their health care providers. Members are also responsible for cooperating with providers in obtaining health care services. Health Net developed member rights and responsibilities statements in accordance with the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). These member rights and responsibilities apply to member's relationships with Health Net, and all participating providers responsible for member care. In addition to member rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, physical or mental handicap, or disability.

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

Members have the right to:

- Receive information about Health Net, its services, its providers and member rights and responsibilities.

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

Members have the responsibility to:

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

Prescription Drug Program

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

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

Select any subject below:

Exclusions and Limitations

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

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

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

Compounded Medications

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

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

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

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.

Diabetic Supplies

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

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

- OneTouch® Verio® IQ meter and test strips
- OneTouch® Ultra® Mini meter
- OneTouch® Ultra® 2 meter
- One Touch® Ultra® Blue test strips

- FreeStyle® test strips
- Freestyle Lite® meter and test strips
- Freestyle InsuLinx ® meter and test strips
- Precision Xtra® meter and test strips

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

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

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

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

Generic Medications

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

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

Generic Substitution Program

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

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

Off-Label Medication Use

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

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

- Approved by the Food and Drug Administration (FDA).

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

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

Life-threatening means either or both of the following:

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

Chronic and seriously debilitating refers to:

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

Participating Pharmacy

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

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

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

Physician Self-Treatment

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

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

Prescription Mail-Order Program

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

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

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

Prior Authorization Process

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

Prior authorization is needed for prescription medications when:

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

There are three options for submitting a prior authorization form:

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

When using the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) it must be electronically submitted, faxed to Pharmacy Services or submitted by any reasonable means of transmission. Faxes are accepted 24 hours a day, and each request is tracked to ensure efficient handling of inquiries from physicians and members. Requests for prior authorization may also be called into Pharmacy Services. Requests are processed within 24 hours for urgent requests and 72 hours for standard requests. If a health care service plan, contracted physician group or utilization review organization fails to notify a prescribing provider of its coverage determination within 72 hours for nonurgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills.

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

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

Exigent Requests

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

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

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

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

Participating physician group (PPG) step therapy and exception process

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

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

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

PPGs must ensure that they have this process in place.

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

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

Quantity of Medication to Be Prescribed

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

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

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

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

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

Recommended Drug List

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

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

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

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

Prior Authorizations

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

This section contains general information on prior authorizations requirements.

Select any subject below:

- Fax Requests
- How to Secure Prior Authorization on Health Net Provider Portal
- NIA - Prior Authorization
- PPO Services Requiring Prior Authorization
- Prior Authorization Process
- TurningPoint
- Peer-to-Peer Review Requests

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 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.

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)

- 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.

Peer-to-Peer Review Requests

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

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

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

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

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

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

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

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

How to request a peer-to-peer review

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

Product Descriptions

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

This section contains general information about Health Net health plans.

Select any subject below:

- 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

This section contains general information about the Elect Open Access health plan.

Select any subject below:

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

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) Los Angeles Riverside (partial county) Sacramento San Bernardino (partial county) San Diego Yolo

PCPs and Self-Referrals

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

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
- 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

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

Overview

Participating Physician Groups (PPG)

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

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

- Alerting the delegated entity regarding possible areas of non-compliance
- Furnishing information regarding regulations
- Developing corrective action plans (CAPs)

- Sharing best practices
- Offering guidance regarding on-site review by outside agencies

Delegation Oversight Committee

The Health Net Delegation Oversight Department is under the direction of the Senior Vice President of Operations. The Delegation Oversight Committee (DOC) is chaired by the Vice President of Delegation Oversight . The committee meets bi-monthly and is comprised of but not limited to senior management representatives from the Health Net Provider Network Management, QI, Health Care Services, Medical Management, Provider Services, Member Services, Actuarial, Appeals and Grievances (A&G), Claims, Encounters, Credentialing, Delegation Oversight, Program Accreditation, and Finance departments. The committee reviews monthly compliance reports and hears recommendations from the Delegation Oversight Workgroup (DOW) and other departments regarding provider compliance deficiencies. The committee collaboratively makes decisions to remedy noncompliance as quickly as possible. Those actions may include closer monitoring by the oversight staff, developing CAPs, escalating to Joint Operations Committees revoking delegation of specific functions, imposing progressive sanctions (such as freezing enrollment and financial sanctions), and when necessary, notifying providers of contract breaches and contract termination.

Credentialing and Recredentialing

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

HEDIS® Reporting

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

Member Complaints, Appeals and Grievances

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

Member complaints with potential quality of care issues are reviewed by the Health Net Clinical Appeals &Grievances Department as part of the appeals and grievances process, which conducts an investigation of each issue and tracks trends for quality of care issues by provider, PPG and type of issue. Provider-specific cases are prepared and presented to the Health Net Peer Review Committee for review and action. During the investigation of potential quality of care issues, the QI specialist may request additional information, medical records or implementation of provider-specific action plans from the PPG. Noncompliance with these requests

may lead to sanctions, such as freezing enrollment of Health Net members until the issue is resolved or possible termination of the Health Net contract.

Preventive Care Guidelines

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

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

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

Notice to Change PPA

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

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

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

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.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

Health Net and Provider Responsibilities

Health Net is required to monitor federal and state exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net plans. Health Net's contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, FEHBP and EEDP federal exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid or Part C and Part D related activities. Health Net, its contracted providers, and their downstream subcontractors or delegated entities must continuously monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website.

The current LEIE is available on the OIG-HHS website. Refer to Frequently asked questions (FAQs) for additional information about the LEIE.

Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare and Medicaid Services to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > References > Suspended and Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion

databases. All parties or entities listed on the EEDP are subject to exclusion from Medicare participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR. Search the WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file. The RPD data file is updated monthly and is available at Healthnet.com. Registered providers can log into the provider portal to access the report located under the regulatory section.

Claims Payment For Excluded Parties

Health Net, its PPGs, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except as documented in the CMS Internet Only Manual, publication 100-16, Chapter 6 - Relationships with Providers, which states, "The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR §1001.1901." FDRs contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Health Net or CMS.

Regulatory Citations for Excluded Requirements

Medicare Advantage organizations (MAOs) and their FDRs must abide by the regulations documented in the Social Security Act 1862(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 422.222, 422.224 and 1001.1901. These federal exclusion requirements are further interpreted and communicated as guidance by CMS in the Medicare Manual, Volume 100-16, Chapters 9 and 21 §50.6.8.

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

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.
- 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.

Facility and Physician Additions, Changes and Deletions

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

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

Select any subject below:

Overview

Participating Physician Groups (PPG) | Ancillary | Hospitals

A participating provider that expands its capacity by adding new or satellite facilities or new participating physicians or other subcontracting providers must notify Health Net in writing at least 90 days before the addition. According to the terms of the Provider Participation Agreement (PPA), the participating provider agrees that Health Net has the right to determine whether the new or satellite facilities or the new participating physicians are acceptable to Health Net.

Addition of New Physicians, Providers or Facilities

Until Health Net approves new subcontracting providers (for example, primary care physicians (PCPs), specialists and ancillary providers), the providers are not allowed to provide covered services under the Health Net PPA. Health Net must be notified in writing at least 90 days before the addition.

Health Net is free to deny participation to any new subcontracting providers and is not obligated to state a cause or explain the denial of the addition or provide the facility, provider or subcontracting providers with any right to appeal or any other due process. Health Net's decision in these cases is final and binding.

In addition, hospitals, ancillary providers and participating physician groups (PPGs) are responsible for providing Health Net with copies of the standard agreements used for their subcontractors. Health Net reviews these standard agreements to ensure compliance with regulatory requirements[1] and directs the facility to make any changes required in order to meet the requirements. Health Net requires hospitals, ancillary providers and PPGs to send sample forms to Health Net for review if they make any changes to their standard agreements or replace them with new standard agreements.

Hospitals, ancillary providers and PPGs must provide Health Net with a copy of the signature page for each subcontractor. Physicians or other subcontractors must be credentialed before they are added to Health Net's network. Hospitals, ancillary providers and PPGs must also provide Health Net a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals, ancillary providers and PPGs are also responsible for informing Health Net when they cease to use a specific subcontractor or when they add a new subcontractor. Health Net periodically sends each hospital, ancillary provider and PPG a list of the physicians or subcontractors Health Net shows as active and under contract with the participating provider. Hospitals, ancillary providers and PPGs are required to review this list and notify Health Net of any additions or deletions. At least monthly, hospitals, ancillary providers and PPGs

must provide Health Net with a list of additions, deletions and address changes, as well as a complete listing annually.

For PPGs only, the Active Physicians Listing is available monthly on the Health Net provider website as an administrative report. Select Provider Reports under Welcome. This report provides PPGs a means to review and revise their records on a monthly basis and communicate physician demographic changes and terminations to Health Net. Additionally, this listing is used by the Health Net Provider Network Management Department to validate PCP and specialist information with the PPG on a quarterly basis.

Hospitals, ancillary providers and PPGs must furnish Health Net copies of any amendments to a contract with a participating provider within 20 days of execution.

[1]Medicare Managed Care Manual, Chapter 11, Section 100.4.

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.

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
- License number
- National Provider Identifier
- Office hours

- Patient age ranges (lowest to highest) seen by provider
- Specialty

- Email address - used for members and is Health Insurance Portability and Accountability Act (HIPAA) compliant

- Practice website
- Hospital affiliation
- Languages other than English spoken by the physician
- Languages other than English spoken by the office staff

- Panel status - Accepting new patients, accepting existing patients, available by referral only, available only through a hospital or facility, not accepting new patients
- Handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/scale (T) - if accessibility is not yes to all, then indicate no

Provider Outreach Requirements

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

Health Net is required to contact directly contracting practitioners biannually, including physicians and other health professionals such as physical therapists (PTs), occupational therapists (OTs) and podiatrists; and annually contact PPGs, hospitals and ancillary providers to validate the accuracy of the information for each provider listed in Health Net's provider directories. The notification includes:

- The information Health Net has in its directories for the provider, including a list of networks and products in which the provider participates.
- A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.
- Instructions on how the provider can update information including the option to use an online interface to submit verification or changes electronically which generates an acknowledgment from Health Net.
- A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the directories is current and accurate or to provide an update to the information required to be in the directories, including whether the provider is accepting new patients for each applicable Health Net network or product. Note: this requirement does not apply to general acute care hospitals. If Health Net does not receive an affirmative response and confirmation from the provider that the information is current and accurate, or as an alternative, receive updated information from the provider within 30 business days, the following will occur:
    - Health Net takes no more than an additional 15 business days to verify whether the provider's information is correct or requires updates. Health Net documents the receipt and outcome of each attempt to verify the information.
    - If Health Net is unable to verify whether the provider's information is correct or requires updates, Health Net notifies the provider 10 business days prior to removal that the provider will be removed from provider directories. The provider is removed from the provider directories at the next required update of the provider directories after the 10 business-day notice period. A provider is not removed from the provider directories if they respond before the end of the 10 business-day notice period. This requirement does not apply to general acute care hospitals.

Health Net will sometimes work with an outside vendor (i.e., Symphony Provider Directory) to reach out to providers to validate practitioner participation and demographic data. Providers are required to respond to requests from Health Net, and/or may update changes as needed directly with Symphony.

Provider Status Change Notification Requirements

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

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

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

Regulator	Contact Information	Line of Business
Department of Managed Health Care (DMHC)	1-888-466-2219 1-877-688-9891 (TDD) www.hmohelp.ca.gov	HMO, POS, HSP, Medi-Cal
California Department of Insurance (CDI)	1-800-927-4357 www.insurance.ca.gov	EPO, PPO

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

Report of Inaccurate Information in Directories

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

At a minimum, Health Net does the following:

1. Contacts the affected provider no later than five business days following receipt of the report.
2. Documents the receipt and outcome of each report, including the provider's name, location, and a description of Health Net's investigation, the outcome of the investigation, and any changes or updates made to the provider directories.

3. If changes to Health Net's directories are required as a result of the plan's investigation, the changes to the online provider directories must be made within the weekly turnaround time. For printed provider directories, changes must be made no later than the next required update or sooner if required by federal law or regulations.

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

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

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

Service and Quality Requirements

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

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

Select any subject below:

- Access to Care and Availability Standards
- 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 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.

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'safter-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.

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 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:

- Prevention or treatment of pregnancy (except sterilization) - California Family Code (CFC) §6925.
- Family planning services, including the right to receive birth control - CFC§6925.
- Abortion services (without parental consent or court permission) - American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997)..

- Sexual assault, including rape diagnosis, treatment and collection of medical evidence; however, the treating provider must attempt to contact the minor's parent/legal guardian and note in the minor's treatment record the date and time of the attempted contact and whether or not it was successful. This provision does not apply if the treating provider reasonably believes that the minor's parent or guardian committed the sexual assault on the minor or if the minor is over age 12 and treated for rape - CFC §6927 and CFC §6928.
- HIV testing and counseling (for children ages 12 and older) - CFC§6926..
- Infectious, contagious, communicable, and sexually transmitted diseases diagnosis and treatment (for children ages 12 and older) - CFC§6926.
- Drug or alcohol abuse (for children ages 12 and older) treatment and counseling except for replacement narcotic abuse treatment - CFC§6926(b).
- Outpatient behavioral health treatment or counseling services (for children ages 12 and older) if in the opinion of the attending provider the minor is mature enough to participate intelligently in the outpatient or residential shelter services and the minor would present a danger of serious physical or mental harm to self or to others without the 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. 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®[1]) survey.

[1]CAHPS® 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

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

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
behavioral health care physician (psychiatrist) that requires prior authorization[3]		
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

Health Net investigates and implements corrective action when timely access to care 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

- 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

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

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 SurveyAffiliate 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.

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 to locate the Approved ICE Documents.

PPGs Only

According to the utilization management (UM) standards, all participating physician groups (PPGs) are required to:

- Approve or deny and process all routine authorization requests within the applicable regulatory time frame of the date of receipt of all information necessary to render a decision.
- If additional clinical information is required, the member and practitioner must be notified in writing within the applicable regulatory time frame of the extension.
- Communicate the decision to the member and practitioner within the applicable regulatory timeframe from the date of the original receipt of the request.
- Approve or deny and process all urgent requests for authorization within 72 hours after the receipt of the request for service.

The regulatory time frames begin when the delegated PPG's UM department receives a request for prior authorization. If the PPG's UM department receives a request for prior authorization of services and it is determined to be the plan's responsibility, the PPG must immediately forward the request to the plan as the regulatory time frames begin at the time of the original request. The commercial Informational Letter to Member

or Provider/Physician carve-out letter(PDF) or Medicare Advantage Informational Letter to Member or Provider/Physician carve-out letter (PDF) serves to advise the member that the PPG's utilization management entity received a prior authorization request for which the PPG is not delegated to conduct a prior authorization review and notifies the member that the request has been forwarded to the plan. The regulatory time frame for the prior authorization review does not reset or stop when this letter is issued.

For additional information, refer to:

- Utilization Management Timeliness Standards - Medicare (PDF)
- Utilization Management Timeliness Standards - Commercial (PDF)

Prior authorization for DSNP services not covered under Medicare but covered under Medi-Cal for members in Exclusively Aligned Enrollment (EAE) counties

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

DSNP prior authorization timelines

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

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

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

Fax prior authorizations to the Medi-Cal fax number listed under Health Net Prior Authorization Department in the Provider Library’s Contacts section and include:

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

Services not covered under Medicare but covered under Medi-Cal

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

- Short-term post-hospitalization housing
- Sobering centers

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

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

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

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

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

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

Credentialing and Recredentialing

Provider Type: Hospitals

Hospitals are required to:

- Assure that the credentialing/recredentialing plan meets 100 percent of National Committee for Quality Assurance (NCQA) credentialing/recredentialing standards, and execute these activities according to that plan.
- Achieve and maintain no less than 70 percent compliance with the plan's medical records criteria for each primary care physician (PCP).
- Measure and report, as a network, data elements necessary to determine compliance with Healthcare Effectiveness Data and Information Set (HEDIS®) quality benchmarks.

- Achieve and maintain compliance with Department of Health and Human Services (HHS) standards.
- Achieve and maintain compliance with Centers for Medicare and Medicaid Services (CMS) standards.
- As applicable, maintain compliance/certification with Joint Commission on Accreditation of Healthcare Organization (JCAHO).

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

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.

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

Disease Management Programs

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

This section contains general information on Health Net's disease management programs.

Select any subject below:

Health and Wellness Program Disclaimer

Provider Type: Physicians | Participating Physician Groups (PPG)

Members have access to our wellness programs, including Sharecare, through current enrollment with Health Net of California, Inc. Our wellness programs are not part of Health Net's commercial medical benefit plans. They are not affiliated with Health Net's provider network, and their services may be revised or withdrawn without notice. These programs, including access to any clinicians, are additional resources that Health Net makes available to enrollees.

Health Net's Health and Wellness Program

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

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

Nurse Advice Line

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

Wellness Programs

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

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

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

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

Disease Management Program

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

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

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

Care Management

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

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

Health Nets Special Needs Plan (SNP) care management (CM)- All SNP and CMC members are automatically assigned CM during the month of CMC membership enrollment with the plan and becoming eligible with Health Net (Health Net or PPG CM assigned per delegation).

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

Health Education Program

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

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

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

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

Health Education Program Offerings

All PPGs should recommend the following core topics: diabetes management, early prenatal education, baby care basics, and for Health Net Medicare Advantage (MA) members, a senior-specific health education or disease management program. Health Net encourages PPGs to provide additional program topics that reflect

the breadth and depth of their members' needs. This includes efforts to identify members who smoke and to refer them to appropriate programs.

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

Category	Examples
Maternal, infant and child health	VBAC, childbirth preparation, breastfeeding
Circulatory	hypertension, hypercholesterolemia
Respiratory	COPD, asthma
Musculoskeletal	back care, arthritis, osteoporosis
Weight management	adults, adolescents, children

Advisory Committee and Program Coordinator

Advisory Committee

Participating physician groups (PPGs) should designate a standing health education advisory committee, including at least one physician and the health education coordinator, to be involved in program planning, evaluation, internal communication, and promotion. This committee can be the same as the PPG Quality Improvement Committee (QIC). The health education advisory committee is responsible for:

- Meeting at least once a quarter.
- Maintaining written records of the advisory committee.

Health Net recommends that PPGs:

- Select advisory committee members to achieve a wide representation of departments in the PPG or geographic locations in a PPG.
- Distribute meeting minutes widely within the PPG so that staff are kept informed about the program.
- Develop a supportive, enthusiastic advisory committee. This helps to ensure a quality program and win support from other physicians and staff.

Health Education Coordinator

PPGs should designate a health education coordinator responsible for coordination and delivery of the health education programs, including PPG staff program orientation and record keeping.

Health education coordinators should spend the following number of hours per week coordinating the health education programs based on the PPG's Health Net membership.

PPG Membership	Hours Per Week
Fewer than 5,000 members	15
5,000 to 10,000 members	15 to 25
10,000 to 20,000 members	25 to 40
20,000 or more members	40 hours or more

The health education coordinator's responsibilities are to:

- Direct members into health education programs based on referrals from Health Net care managers or health risk assessment (HRA) results.
- Be accessible to Health Net members seeking information, suggestions and problem solving.
- Coordinate satellite programs (unless another coordinator is designated to do this).
- Maintain all program records and make them available for the site evaluation.

Health Net recommends that:

- Health education coordinators have one of the following credentials: masters of public health (MPH), certified health education specialist (CHES), registered nurse (RN), physician assistant (PA), family nurse practitioner (FNP), registered dietitian (RD), or a Masters or Bachelors degree in health education, nutrition or exercise physiology.
- Health education coordinators receive administrative and medical staff support.

Health Education Program Protocols

Health education program protocols are recommendations for success when providing classes on diabetes, early prenatal education and baby care basics. Program protocols also include disease-specific education programs and smoking cessation for participating physicians groups (PPGs).

Diabetes Education Program Protocols

All diabetes education programs should encourage an active partnership between the member, the member's family and the health care provider. Such partnerships can improve member adherence to treatment plans and enable families to better support efforts to control the member's diabetes.

It is also important that all diabetes education programs emphasize the concept of self-management of diabetes rather than teaching individual skills.

The following topics are required for all diabetes education programs:

- Understanding diabetes:
  - Basic definition and facts about diabetes
    - Normal and abnormal glucose metabolism
    - Classifications: Type I and Type II
  - Factors in the development of Type I and Type II diabetes
  - Signs and symptoms of diabetes
  - Chronic complications
    - Retinopathy
    - Neuropathy
    - Nephropathy
    - Cardiovascular disease
    - Sexual dysfunction/impotence
- Medications (as indicated):
  - Oral medication
  - Insulin use
    - Review of insulin's action
    - Injection techniques
    - Dosage
    - Insulin reaction (hypoglycemia)
    - Hyperglycemia
- Strategies to control diabetes:
  - Blood glucose monitoring and interpretation of results
  - Nutrition and meal planning
  - Exercise and activity
  - Routine tests to measure control
    - Annual retinal examination
    - Glycosylated hemoglobin (HbgA1c) screening every three months
    - Annual microalbumin creatinine urine screening
    - Blood pressure screening at every visit
    - Cholesterol screening once a year
    - Foot examination at every visit
- Living with diabetes:
  - Preventing, detecting and treating complications
    - Skin, eye and dental care
    - Immunizations
    - Infections
    - Foot and leg care
    - "Sick day" rules
    - Identification (such as MedicAlert)
  - Psychological adjustment
  - Lifestyle considerations (nutrition, physical activity and smoking cessation)
  - Family involvement
  - Community resources
- Patient self-care:
  - Behavior change strategies
  - Goal setting
  - Risk factor reduction
  - Problem-solving

Adapted from the Journal of Clinical and Applied Research and Education, Diabetes Care, American Diabetes Association, Volume 38: Supplement 1, January 2015.

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis. Health Net recommends that participating physician groups (PPGs) also offer seminars or classes at least monthly. The diabetes education program may also be a one-session class, multiple-session classes, one-to-one counseling, or any combination of these modes. The recommended minimum length for group programs is three to four sessions, each two hours in length. Classes and seminars should be followed by a one-hour, one-to-one follow-up appointment to develop individualized care plans.

Participant Tracking

PPGs should give documented feedback regarding a member's program attendance to the physician for him or her to include in the member's medical chart.

Disease-Specific Program Protocols

It is important that all disease-specific education programs encourage an active partnership between the patient, the patient's family, and the health care provider. Such partnerships can improve patient adherence to treatment plans and enable families to better support the patient's efforts to manage his or her disease.

Content may be expanded and additional components incorporated as indicated by the specific disease or condition.

All disease or condition-specific education programs should cover the following topics, as applicable:

- Understanding the disease:
  - Basic definition of the disease and affected physiological processes
  - Causes of the disease
  - Signs and symptoms of the disease
- Medications (if applicable):
  - Different types of medications
  - Purpose of medications and how they work
  - Common side-effects and coping strategies
  - Importance of medication compliance
  - Methods of maintaining compliance with the medication regimen
- Living with the disease:
  - Treatment of the disease:
    - Development of treatment/care plan
    - Routine medical visits and tests
    - Avoiding, detecting and treating complications, if applicable
- Lifestyle considerations:
  - Nutrition
  - Exercise
  - Other considerations specific to the disease
  - When to call a medical professional immediately
  - Psychosocial issues
  - Importance and role of family/caregivers

- Patient self-care:
  - Importance of patient compliance with treatment/care plan
  - Self-monitoring, as appropriate
  - Behavior change strategies
  - Individual goal setting

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis and should be at least one hour in length. Health Net recommends that participating physician groups (PPGs) offer seminars or classes, which are at least two hours in length, at least monthly. Programs may be offered as a combination of quarterly group programs with one-to-one counseling available in the other two months, as long as both programs are equally available to members.

Participant Tracking

PPGs should document feedback regarding a member's program attendance to be given to the physician for him or her to include in the member's medical chart.

Patient Health Education

Patient health education is the effort to keep members fully informed about the availability and use of participating physician group (PPG) facilities and services.

PPGs must offer patient health education as a covered service to members in two main areas:

- Proper use of Health Net and PPG services.
- Health maintenance and improvement, including personal health care measures and counseling.

Health Net has developed an enrollment packet, which includes a plan overview that explains to members how to use Health Net and PPG services. This enrollment packet is distributed to members, along with identification (ID) cards and the member's Schedule of Benefits. Members are directed to contact their PPGs if they have questions.

PPG Responsibilities

PPGs must make an effort to keep members fully informed about the availability and use of PPG facilities and services. New member interviews, letters of introduction and the Health Net Member Services Department provide sources of ongoing education and information.

Health education services, including educational activities and publications that contain instructions on achieving and maintaining physical and mental health and preventing illness or injury, should be developed by the PPG.

Health Net's Pre-recorded Health Information

Health Net offers a library of pre-recorded information on a variety of health topics to all Health Net members through the AudioHealth Library®. Members may access the library by contacting the Health Net Member Services Department.

Responsibilities for Health Education Programs

Program Delivery Site

Participating physician groups (PPG) and its participating providers should dedicate and maintain a physical environment or setting conducive to the delivery of health education programs and optimal learning and ensure that is appropriate for its Health Net membership. Specifically:

- Member education must not occur in an examination or a waiting room during clinic hours.
- All programs should be conducted onsite or at an appropriate offsite location.
- The sites must be accessible to individuals who have physical limitations.

Program Evaluation and Tracking

Health Net recommends that groups evaluate all classes and seminars using a written participant evaluation form. The evaluation form should include an overall satisfaction question using a five-point rating scale, such as:

5	4	3	2	1
Extremely Satisfied	Very Satisfied	Satisfied	Not Very Satisfied	Extremely Dissatisfied

Written participant evaluation forms are not required for one-to-one counseling sessions.

PPGs should conduct follow-up telephone calls or use other means to evaluate the quality of one-to-one counseling sessions.

Program Promotion

PPGs should promote all programs to Health Net members and PPG staff. Health Net encourages PPGs to mail promotional materials to Health Net members at least once per year to promote all health education programs. Suggested promotional activities include:

- Flyers and posters in waiting areas.
- Medical group newsletters via direct mail.
- Telephone recordings.

PPGs may not use the Health Net corporate logo on material without Health Net's permission.

Record-keeping Responsibilities

PPGs should use and maintain appropriate medical and non-medical records (for example, attendance lists, evaluation forms, patient education sign-in sheets, and documentation of feedback to physicians).

Specifically, PPGs should maintain the following documentation:

- Attendance records or one-to-one education sign-in sheets identifying Health Net members.
- Written program evaluations for all programs (except one-on-one counseling).
- A system to document smoker identification and referrals to a smoking cessation program.
- Minutes from advisory committee meetings.
- A physician feedback system of participant attendance and progress in the diabetes and early prenatal programs, which provides a link between the referring physician, patient, and health education program:
  - Attendance feedback is documented in the member's medical record or in a central file.
  - A random sampling of medical records or copies of feedback records may be reviewed during the annual site evaluation.

  PPGs may also document the member's progress, response to education and attendance in other programs and share this information with the member's physician.

Speakers Bureau

Participation in Health Net's Speakers Bureau program is optional. Participating physician groups (PPGs) are asked periodically to provide presentations or screenings to Health Net employer groups.

For more information, select any subject below:

- Smoking Cessation Program

Smoking Cessation Program

Provider Type: Physicians | Participating Physician Groups (PPG)

Participating physician groups (PPGs) can implement an ongoing, systematic process for identifying members who smoke. Members may be referred to programs offered by the PPG or the Craving to Quit program.

Craving to Quit Program[1]

Sharecare is a vendor that provides an enhanced wellness program to members. Sharecare's tobacco cessation program is designed to help users who are ready to quit to permanently break their addiction to tobacco. Participants will utilize a digital support approach that provides mobile and online tools, resources and messaging features with trained experts.

Craving to Quit is an evidence-based 21-day smoking and vaping cessation program delivering treatment via app or website. The program helps retrain the brain using mindfulness to break the habit loop.

In the United States, 70 percent of smokers want to quit smoking, but only 10 percent will do so successfully on their own. This program’s tools and learning modules can maximize your odds of successfully quitting. Some of the tools available include:

- Daily tracking

- Daily coaching
- Daily nudges
- An online community
- A quitting pact
- 40 additional optional modules
- Mindfulness tools

Enrollment in the tobacco cessation program is initiated by Eligible Users who are ready to quit smoking.

The digital service option provides up to twelve (12) months of unlimited support for eligible participants.

Refer members other than Medicare members to the Craving to Quit telephonic tobacco cessation program to speak to an enrollment specialist.

[1]Craving to Quit is not offered for Health Net Medicare members.

Other Tobacco Cessation Resources

Kick It California (formerly California Smoker's Helpline) is a tobacco cessation program available to Health Net members. The program offers specialized services for teens, pregnant smokers, individuals who chew tobacco, and e-cigarette users, and extends information on how to help a friend or family member quit tobacco use. Telephonic coaching is available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese) and text programs may be obtained in English or Spanish. Members can learn more by calling Kick It California at 800-300-8086 or online at www.kickitca.org.

Recommendations

Providers should assess and document smoking status as part of the vital signs he or she collects at each clinical visit for every member. Adding smoking status to the vital signs assessment, an activity usually completed by a nurse or medical assistant prior to the physician's encounter, ensures that all smokers are identified.

Nicotine Replacement Therapy

Health Net is responsible for the approval of nicotine replacement therapy (NRT) for prescription-only and other smoking cessation products for members who have smoking cessation benefits. If applicable, providers can complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) (for approval of NRT), indicating that the member is using it for smoking cessation and is enrolled in a smoking cessation program.

Health Management Programs

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

This section contains information on Health Net's health management programs.

Select any subject below:

Behavioral Health Services

Provider Type: Participating Physician Groups (PPG)

Health Net has quality initiatives to improve members' physical and mental health outcomes. Health Net focuses on various psychotropic medications, including antidepressant medication management. For example, eligible members with gaps in their antidepressant medication refills, and who are diagnosed with depression, receive automated or live outreach conducted by clinical pharmacists to remind them to continue taking their medications, refill their prescriptions and report any medication problems or concerns to their providers.

Most Health Net members appropriately seek depression treatment from their primary care physicians (PCPs), which is why Health Net provides physicians and participating physician groups (PPGs) with tools, such as Provider Tip Sheets, to support the management and coordination of care for members diagnosed with behavioral health conditions.

In an effort to increase awareness of the importance of identification and management of behavioral health conditions, among both providers and members, Health Net has been developing and posting:

1. Member online news articles to educate members on behavioral health (i.e., mental health and substance use), how to recognize the need for help, the availability and types of treatments, and the importance of treatment, medication adherence, and communicating with their providers.
2. Provider online news articles on the importance of monitoring, managing, and coordinating care and information exchange between medical and behavioral health providers, and available resources for easy reference and assistance.

Health Net's Health and Wellness Program

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

Health Net's member wellness portal is a central hub for all of the wellness programs and activities. The wellness programs were created to engage people in their health with personalized tools and achievable goals. Members can feel confident in their ability to make positive and lasting behavioral changes.

Language Assistance Program and Cultural Competency

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

This section contains general information on Health Net's cultural and linguistic services.

Select any subject below:

- Language Assistance Program and Cultural Competency
- Language Assistance Program and Cultural Competency (Hospitals only)

Language Assistance Program and Cultural Competency

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

The Health Care Language Assistance Regulations require all health plans to provide language assistance and culturally responsive services to members with limited English proficiency (LEP), limited reading skills, who are deaf or have a hearing impairment, or who have diverse cultural and ethnic backgrounds. To comply with this requirement, Health Net created the Language Assistance Program (LAP). Health Net's LAP offers interpreter services to members to ensure that Health Net members with LEP are able to obtain language assistance while accessing health care services. Health Net's LAP supports Health Net members' linguistic and cultural needs. Additionally, Health Net offers interpreter support and requires all participating providers to take evidence-based cultural competency courses. Providers are encouraged to take courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Health Net participating providers must comply with Health Net's LAP as defined in this section.

Compliance Requirements

Health Net participating providers, including case management and utilization management (UM)-delegated providers, are required to comply with Health Net's LAP by using the following:

- Interpreter services - Use qualified interpreters for members with LEP. Interpreter services are provided by Health Net at no cost to providers or members. Interpretation services include face-to-face (in-person), telephone, video remote, sign language (including American Sign Language and tactile), and closed captioning interpretation. Please request interpretation services at least 5-10 days before the scheduled appointment.

    - Telephone interpreters are available in more than 150 languages. Advance notice for telephone interpreters is not required.
- Translation services - Provide Health Net, upon request and in a timely manner, with the documents sent to members. If a Health Net member requests translation or an alternative format of an English document that was produced by a delegated PPG on Health Net's behalf, the provider must refer the member to the Health Net Member Services phone number listed on the member's identification (ID) card. When Member Services receives the request from the member, Health Net contacts the provider requesting a copy of the specific English document for translation or alternative format. The provider must submit the document within 48 hours of Health Net's request. Translation is only available in threshold languages
- Tagline and non-discrimination notice - Include a Health Net-specific tagline and non-discrimination notice with all member informing materials going to Health Net members.

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
Commercial Non-discrimination Notice (PDF)	Non-discrimination Notice CalViva Health (English) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (English) (PDF)	Non-discrimination Notice Medi-Cal (English) (PDF)
	Non-discrimination Notice CalViva Health (Hmong) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (Spanish) (PDF)	Non-discrimination Notice Medi-Cal (Arabic) (PDF)
	Non-discrimination Notice CalViva Health (Spanish) (PDF)		Non-discrimination Notice Medi-Cal (Armenian) (PDF)
			Non-discrimination Notice Medi-Cal (Cambodian) (PDF)
			Non-discrimination Notice Medi-Cal (Chinese) (PDF)
			Non-discrimination Notice Medi-Cal (Farsi) (PDF)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
			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.
- Independent Medical Review (IMR) Application - Locate translated IMR applications on the Department of Managed Health Care (DMHC) website at www.dmhc.ca.gov and make them available to members upon request.
- Medical record documentation - Document the member's language preference (including English) and the refusal or use of interpreter services in the member's medical record.

Interpreter Services

Health Net offers 24-hour access to interpreter services at no cost. To obtain interpreter services, members and providers can contact Health Net Member Services at the phone number located on the member's ID card. Telephone interpreters are available at the time of the appointment without prior arrangement. Allow adequate time before the appointment to get the telephone interpreter on the line.

Language assistance services include:

- Qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics.
- Telephone interpreters available in more than 150 languages and on short notice in support of last-minute appointments to meet the revised access and availability standards.

- Face-to-face (in person), telephone, video remote, and sign language interpreter services, closed captioning interpretation services are available when requested a minimum of 10 business days in advance of the appointment.

- Support to address common communication challenges across cultures.
- Oral translations of member materials in more than 150 languages.

Provider Responsibilities

Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that interpreters are available at the time of the appointment.
- Ensure that members with LEP are not subject to unreasonable delays in the delivery of services, including accessing providers after hours.
- Provide interpreter services at no cost to members.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to members with LEP that are as effective as those provided to members without LEP.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in their medical record. Providers are strongly encouraged to document the use of any interpreter in the member's record.
- Provide translated member grievance forms to members upon request.

Providers are prohibited from:

- Requesting or requiring an individual with LEP to provide their own interpreter.
- Relying on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Relying on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
- Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

Providers are responsible to provide translated care plans in threshold languages to members with LEP and/or their caretakers. Care plans must be written at a 6th grade reading level for Medi-Cal and 8th grade reading level for Commercial members. Health Net provides the translations in threshold languages upon request with documentation that the content is at the applicable reading level. Refer to the provider Interpreter Services Quick Reference Guide for assistance.

- Interpreter Services Flyer (PDF) (Commercial and Medi-Cal)
- Interpreter Services Flyer (PDF) (CalViva Health)
- Interpreter Services Flyer (PDF) (Community Health Plan of Imperial Valley)

A Language Identification Poster is available to print and post in providers' offices.

- Commercial, Medi-Cal Language Identification Poster (PDF)
- CalViva Health Language Identification Poster (PDF)
- Community Health Plan of Imperial Valley Language Identification Poster (PDF)

For more information about how to work with an interpreter, refer to the Health Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations – Health Net (PDF), Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – Community Health Plan of Imperial Valley (PDF) or Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – CalViva Health Industry Collaboration Effort (PDF).

Cultural Competency Training

All Health Net participating providers must take cultural competency training. We suggest that you take one of the trainings offered by the Office of Minority Health (OMH). The trainings are computer-based training for health care providers. OMH developed these no-cost trainings to give providers competencies to better treat an increasingly diverse population. The general training is available at Think Cultural Health. OMH also has a no-cost, accredited maternal health care training available at Think Cultural Health Education. Health Net does not sponsor these trainings or materials.

The Institute for Healthcare Improvement has free downloads to improve plain language communication with patients under the Ask Me 3® program.

You can also access Health Net's cultural competency training for providers and PPG staff or contact Health Net's Health Equity Department for customized training to meet your needs.

Medi-Cal providers may have the completion of cultural competency training listed in the provider directory. The provider directory indicates a "Y" if the provider has completed two hours of cultural competency training within the last 24 months. Notify Health Net by email after completing the training at 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

Health Net maintains an ongoing Language Assistance Program (LAP) to ensure members with limited English proficiency (LEP), limited reading skills, who are deaf or have hearing impairment, or who have diverse cultural and ethnic backgrounds have appropriate access to language assistance while accessing health care services. Health Net encourages providers to consider evidence-based cultural competency courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Hospital Requirements

Health Net's participating hospitals are subject to requirements to provide language interpreter services for their patients pursuant to federal and state law. Health Net expects its participating hospitals to fully meet these obligations, notwithstanding Health Net's separate obligations to meet all requirements under the Health Care Language Assistance Regulations to provide language interpreter services for its members at all points of contact.

Interpreter Services Requirements

Section 1557 of the Affordable Care Act (published as 45 CFR 92) provides guidance on interpreter services, including the use of bilingual staff that act as interpreters. The guidance is summarized below.

- Provide services to individuals with LEP and individuals with a hearing incapacity that are as effective as those provided to members without LEP.
- Providers may not request or require an individual with LEP to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not rely on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
    - Health Net members have the right to file a grievance with Health Net if their language needs are not met. Members can also file a discrimination complaint with the Office of Civil Rights if their language needs are not met.

  Health Net has processes in place to ensure that members with LEP can obtain Health Net's assistance in arranging for the provision of timely interpreter services to the extent its participating hospitals are not required under state and federal law to provide a particular Health Care Language Assistance Regulations-required interpreter service.

Health Net monitors its participating hospitals for deficiencies in interpreter services and takes appropriate corrective action to address these deficiencies in the delivery of interpreter services to Health Net members.

Providers who would like to schedule trainings on topics such as cross-cultural communication, health literacy or accessing interpreter services should contact Health Net's Health Equity Department.

For additional information, refer to Health Net's Interpreter Services or the Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF).

Quality Improvement Program

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

This section contains general information on the Health Net Quality Improvement (QI) program.

Select any subject below:

- Overview
- 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

Overview - Quality Improvement

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

The Health Net Quality Improvement (QI) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals.

Health Net's Population Health Management strategy provides usage risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social determinants of health (needs at all stages of life. The QI program impacts the following:

1. **Health Net members** in all demographic groups and in all service areas in which Health Net is licensed.
2. **Network Providers**, including physicians, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
3. **Aspects of Care**, including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.

4. **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
5. **Communication** to meet the cultural and linguistic needs of all members.
6. **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
7. **Provider/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
8. **Services Covered by Health Net**, including preventive care; primary care; specialty care; telehealth, ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing care; home health care; long term care (LTC), Long-Term Services and Supports (LTSS): Community Based Adult Services (CBAS) which meets the special, cultural and linguistic, complex or chronic needs of all members.
9. **Internal Administrative Processes** which are related to service and quality of care, including customer service, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

Except for Molina, Health Net does not delegate its QI program or oversight responsibilities to PPGs, participating providers, hospitals, or ancillary providers. PPGs, participating providers, hospitals, and ancillary providers are required to comply with the standards and requirements set forth by Health Net, included in this operations manual.

Health Net regularly communicates information about Health Net's QI program goals, processes and outcomes as they relate to member care through provider updates, committee meetings and other forums. QI program information is also available to providers by request through Health Net's Provider Services Center (Commercial, Medicare Advantage, Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley).

Health Net Quality Improvement Committees

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

The Health Net Quality Improvement Committee (HNQIC) is responsible for oversight of the Quality Improvement (QI) program and monitoring the quality and safety of care and services rendered to Health Net members.

The HNQIC structure ensures providers participate in the planning, design, implementation, and review of the QI program. External providers participate on the HNQIC along with representatives from MHN (Health Net's behavioral health division), the pharmacy department, Provider Network Management, Customer Service Operations, and Medical Management, including credentialing, peer review and utilization management.

HNQIC functions include the following:

- Review and approval of the annual QI and UM program description, work plan and evaluation.

- Reporting to the board of directors or executive management team at least annually.
- Ensuring external practitioner participation in the QI program through planning, design, implementation or review.
- Recommending policy decisions, evaluating the results of QI activities, instituting needed actions, and ensuring follow-up, as appropriate.
- Reviewing behavioral health care initiatives and outcomes.
- Analyzing and evaluating the results of focused audits, studies, quality of care, safety issues, and quality of service issues.
- Monitoring for compliance and other QI findings that identify trends and opportunities for improvement.
- Providing input and recommendations for corrective actions and monitoring previously identified opportunities for improvement.
- Overseeing the CMS QI program and receiving periodic reports on CMS-required QI activities.
- Overseeing the state and federal regulatory QI Program requirements by reviewing reports on required QI activities.
- Providing support and guidance to health plan associates on QI priorities and projects.
- Monitoring data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
- Addressing utilization management and QI activities which affect implementation and effectiveness of the QI program and interventions.

Credentialing/Peer Review Committee

The Credentialing/Peer Review Committee verifies and reviews practitioners and organizational providers who contract to render professional services to Health Net members for training, licensure, competency, and qualifications that meet established standards for credentialing and recredentialing. The Credentialing Committee ensures Health Net's credentialing and recredentialing criteria for participation in the Health Net network are met and maintained for all lines of business, as defined by the regional health plans. The HNQIC delegates authority and responsibility for credentialing and recredentialing peer reviews to this committee. This committee is also responsible for peer review activities and decisions regarding quality improvement follow-up on service and clinical matters, including quality of care cases. The committee provides a forum for instituting corrective action as necessary, and assesses the effectiveness of these interventions through systematic follow-up for all lines of business for both inpatient and outpatient care and services.

This committee reports quarterly to the HNQIC and provides a summary of activities to the Health Net board of directors. Membership includes practicing medical directors or practitioners (representing primary and specialty disciplines) from PPGs representing each region (northern, central and southern California).

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee ensures appropriate and cost-effective delivery of pharmaceutical agents to Health Net membership. Committee responsibilities include the review and approval of policies that outline pharmaceutical restrictions, preferences, management procedures, explanation of limits or quotas, the delineation of Recommended Drug List (RDL) exceptions, substitution and interchange, step-therapy protocols, and the adoption of prescription safety procedures.

The P&T Committee includes a Health Net medical director, practitioners from PPGs that represent primary care and specialty disciplines, and clinical pharmacists.

A Pharmacy and Therapeutics (P&T) Committee is comprised of actively practicing physicians, medical directors and clinical pharmacists who review the efficacy and safety data of medications using an evidence based process in order to make clinically appropriate utilization management recommendations to health plans and pharmacy benefit managers. P&T Committee members also consider the potential for medication misuse or abuse, experimental or off-label use, and required level of laboratory or safety monitoring. P&T Committee utilization management tools include prior authorization criteria, quantity limits and step therapy.

Delegation Oversight Committee

Health Net may delegate responsibility for activities associated with utilization management (UM) and administrative services to its PPGs.

The Health Net Delegation Oversight Committee (DOC):

- Provides systematic oversight and regularly evaluates Health Net's PPGs or contracting vendors to assure compliance with delegated duties.
- Oversees PPG compliance with health plan and regulatory requirements pertaining to the delivery of care and services to members.
- Assesses and determines delegation for each component of the delegated responsibilities, including UM, claims, credentialing, and administrative services.
- Communicates in writing all delegation decisions, recommendations and requests for corrective action plans (CAPs) to the PPGs.
- Reports quarterly to the HNQIC.

Specialty Network Committee

Does not apply to Dual Special Needs Plan members.

The Specialty Network Committee sets standards for the Health Net participating bariatric performance centers, coordinates with the Centene Corporate Transplant Program regarding quality outcomes for contracted transplant centers, guides members to specialty network providers, monitors performance, and issues requests for CAPs. This committee meets quarterly, with ad hoc meetings scheduled as necessary, and reports annually to HNQIC.

Clinical Quality Improvement Workgroup

The QI Clinical and Service Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The Clinical QI Workgroup also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety, access to care, services, and member and provider satisfaction. The Clinical QI Workgroup consists of a core group of QI associates, a consulting physician and ad hoc members pertinent to the report topic. At each meeting, there is focused discussion on report findings, barriers, and interventions for the purpose of making and implementing decisions regarding QI activities. The Clinical QI Workgroup meets at least four times per year and reports significant findings to the HNQIC.

Participation in Public Reporting of Hospital Performance

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

Health Net requires that all urban, acute care participating hospitals annually report safety and quality data results to at least one readily available consumer outlet, such as the Leapfrog Group Patient Safety Survey and the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website.

WebMD's Hospital Advisor and publiclyavailable hospital quality information

Health Net's Hospital Advisor Tool from WebMD offers members a wide range of details about the quality performance of individual hospitals, including rates of complications and mortality, the quantity of specific procedures performed at the facility, typical lengths of stay, average cost, and a variety of quality and patient safety indicators. The data is based on sources such as state reporting, survey results from The Leapfrog Group, CMS hospital quality indicators, and hospital patient satisfaction information. Health Net promotes member use of hospital quality data in mailed member letters and newsletters, online, by email, and in paid social media campaigns.

Similar data can be accessed by providers at the following publicly available websites:

- Cal Hospital Compare
- The Centers for Medicare and Medicaid Services resource Care Compare
- The Leapfrog Group (see below) for hospital ratings and Hospital Safety Grades

The Leapfrog Group

The Leapfrog Group is an organization founded to promote patient safety and improve quality of care. As a Leapfrog Partner, Health Net promotes participation in the Leapfrog hospital and ambulatory surgery center (ASC) surveys, which offer consumers key information about a facility's quality and safety performance with respect to established patient safety practices and progress toward national quality standards. Examples of hospital survey measures include:

- Computerized physician order entry.
- Intensive care unit physician staffing.
- Evidence-based hospital referral.
- Safe practices score based on National Quality Forum standards.

Participation in Leapfrog's surveys offers hospitals and ASCs the ability to assess their strengths and weaknesses in areas such as hospital-acquired infection scores and evidence-based care to address common acute conditions. In addition to making these survey findings publicly available, Leapfrog publishes a Hospital Safety Grade. This composite score assigns individual hospitals a letter grade to indicate hospital performance on patient safety according to an analysis of up to 27 quality measures. For more information, visit The Leapfrog Group.

Quality Improvement HAC Program

Provider Type: Hospitals

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

Quality Improvement Program

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

Health Net's Quality Improvement (QI) program provides the infrastructure for all managed care products. The QI program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes and member and provider satisfaction. The purpose and goals of the QI program are to:

- Establish standards for both the quality and safety of clinical care and service, as well as monitor and evaluate the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.
- Support Health Net's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-

based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

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

The Health Net QI program includes a written program description and an annually revised QI work plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement Committee (HNQIC), Health Net Community Solutions (HNCS) UM/QI Committee, and the Health Net board of directors approves and monitors the annual Health Net QI program and the QI work plan. The board of directors receives quarterly reports regarding medical affairs, QI, utilization management (UM), and pharmacy.

Quality Improvement Program and Compliance and HEDIS

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

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

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

- California Quality Collaborative (CQC), a program that seeks to improve clinical care and service for all Californians by providing strategies at the point of care. Various programs are available to providers to improve chronic disease care, patient satisfaction and efficiency. For a listing of educational programs and patient satisfaction and condition management resources, providers can visit www.calquality.org.
- The Leapfrog Group: Health Net works closely with The Leapfrog Group, purchases their data, and promotes their ratings and standards to network hospitals, members and the community.
- Cal Hospital Compare: Health Net collaborates with Cal Hospital Compare on a range of issues and contracts with them to obtain Poor Performer and Honor Roll reports and associated data files to inform hospital quality initiatives. .

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	
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

Overview

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.

Health Net's denial letter states the medical and, if applicable, scientific reasons for the denial and any alternative treatment that Health Net does cover. The denial letter also includes an application and instructions for the member to utilize the DMHC Independent Medical Review (IMR) Program.

Participating providers should not direct members to contact Health Net for approval of these services. It is the requesting provider's responsibility to provide all pertinent information and documentation directly to Health Net.

Experimental medical and surgical procedures, equipment and medications, are not covered by Original Medicare or under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community.

DMHC Notices of Translation Assistance, Forms and Applications

DMHC Notices of Translation Assistance

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

Translated DMHC Complaint (Grievance) Forms

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

Translated DMHC IMR Applications

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

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.

Third-Party Liability

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

This section contains general information on third-party liability responsibilities.

Select any subject below:

- Coverage Explanation

Coverage Explanation

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

If a subscriber or member is injured through an act or omission of another person, the participating provider must provide benefits in accordance with the Evidence of Coverage (EOC) or Certificate of Insurance (COI). If the injured member is entitled to recovery, the plan and the participating provider rendering services to the member are entitled to recover and retain the value of the services provided from any amounts received by the member from third-party sources.

When the plan pays a claim with an injury or trauma diagnosis code that may be related to a motor vehicle accident, employment or possible other third-party liability, the plan may use an outside vendor, the Rawlings Company, to investigate for determination of other coverage liability. Rawlings' expertise and automated system capabilities are used to identify claims where a third party may be responsible for payment. Rawlings may directly correspond with providers requesting refunds when another liability coverage is determined to be primary. If a provider receives a refund request letter from the Rawlings Company that includes the primary coverage insurance information in the event that the provider has not already been provided the other coverage information by the member or billed the primary carrier, the provider is expected to bill the other coverage and refund the plan, via the Rawlings Company, within a reasonable time period. Failure to comply with timely filing guidelines when overpayment situations are the result of another carrier being responsible does not release the participating provider from liability.

Reimbursement to the plan or the participating provider under this lien is based on the value of the services the member receives and the costs of perfecting the lien. The value of the services depends on how the participating provider was paid and the lien amount is determined as permitted by law. Unless the money that the member receives comes from a workers' compensation claim, the following applies:

- The amount of the reimbursement that the member owes the plan or the participating provider is reduced by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines that the member was responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be the lesser of a *pro rata* reduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

Provider and Member and Responsibilities

Provider Responsibility

The participating provider must question the member for possible third-party liability (TPL) in injury cases. Often, the member does not mention that this liability exists, having received complete care without charge from the participating provider and may not feel that it is necessary. The participating provider must check for this liability where treatment is being provided. The participating provider must develop procedures to identify

these TPL cases. After TPL has been established, the participating provider must provide the plan with the information using the Authorization to Treat a Member form or other correspondence.

Submit Itemized Charges and Member's Statement of Liability for Reimbursement

When the participating provider seeks reimbursement from the third-party payer, it must do so by filing an appropriate lien. This may be done by submitting an itemized statement for paid claims or value of services rendered, whichever is appropriate, and a member's statement of third-party liability to any person or entity which may receive payments made in a settlement or judgment in the TPL case.

Lien Coordination

The participating provider must coordinate with any participating providers that assert a lien and ensure that all communication received by the member in this regard is consistent. In the event that the PPG is assigned recovery of a hospital lien, the plan must be advised promptly.

Calculation of Lien Amount

The participating providers' staff is responsible for remaining current on legal developments regarding TPL recoveries. In determining the amount of the lien, follow guidelines prepared by counsel. Recoveries for coordination of benefits (COB), duplicate payments and the like should be reconciled promptly. Where the participating provider asserts the contractual lien based on Evidence of Coverage (EOC) or Certificate of Insurance (COI), it is subject to:

- A reduction by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines the member is responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be lesser of a pro ratareduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

It is the participating provider's responsibility to act reasonably in pursuing a lien.

Member Responsibility

An injured member entitled to recovery is required to:

- Inform the plan and participating providers of the name and address of the third party, if known, the name and address of the member's attorney, if using an attorney, and describe how the injuries were caused.
- Complete any paperwork that the plan or the participating providers may reasonably require to assist in enforcing the lien.

- Promptly respond to inquiries from lien holders about the status of the case and any settlement discussions.
- Notify lien holders immediately upon the member or the member's attorney receiving any money from third parties or their insurance companies.
- Hold any money that the member or the member's attorney receives from third parties or their insurance companies in trust, and reimburse the plan and the participating providers for the amount of the lien as soon as the member is paid by the third party.

Utilization Management

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

This section describes Health Net's utilization management program and processes.

Select any subject below:

- 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.

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

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

Health Net's care management program is available to all members to:

- Create a comprehensive system of medical management,
- Use resources and managed health care expertise collaboratively, and
- Provide a full complement of coordinated cost-effective care.

The Health Net care management program provides individualized assistance to members experiencing complex, acute or catastrophic illnesses. The focus is on early identification of and engagement with high-risk members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs and improve health and functional status, resulting in favorable outcomes.

Health Net's care management program uses qualified nurses, social workers and medical directors to provide a fully integrated network of programs and services for the management of high-risk, chronic and catastrophically ill or injured individuals.

High and moderate risk Special Needs Plans (SNPs) members who are actively engaged are managed by the health plan’s case manager in order to implement their individual care plan which is designed to support the member’s optimal level of wellness.

Program Goals

The Health Net care management program goals are to achieve, in collaboration with providers, the following:

- **Quality health outcomes** - Identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.
- **Cost effectiveness** - Health Net is committed to measuring the effectiveness of the care management program. Additionally, with timely and accurate encounter reporting from participating physician groups (PPGs), Health Net can provide clinical and cost information feedback to PPGs to assist them in enhancing the performance of their medical management and disease-state management programs.

- **Resource efficiency** - The Health Net care management team works with internal and external stakeholders to develop outcome studies and educational programs to improve the efficiency and effectiveness of Health Net's and the PPG's care management activities.

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

months or less, health status continues to worsen and the emergency department (ED) or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

Referrals

Palliative care services provide extra support to current benefits.

Providers can refer an eligible member to palliative care. Send a Care Management Referral Form (PDF) and related medical records by email or fax to the Care Management Department. To process the request correctly, the following information must be included on the request:

- Diagnosis code – Z51.5
- Procedure code – S0311
- Units – 6 (equals 6 months)
- Select the contracted provider of choice from the Health Net Contracted Palliative Care Providers list (PDF).

Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in section A. below, and at least one of the four requirements outlined in section B.

Members under age 21 who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in section C. below, consistent with the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
    - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    - b.Participate in advance care planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive heart failure (CHF): Must meet (a) and (b)

- a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
- b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b)
   - a. The member has a forced expiratory volume (FEV) of one less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   - b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. Advanced cancer: Must meet (a) and (b)
   - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver disease: Must meet (a) and (b) combined or (c) alone
   - a.The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
   - b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   - c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

Must meet 1. and 2. listed below. Members under age 21 may be eligible for palliative care and hospice services concurrently with curative care.

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
   - a. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
   - b. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
   - c. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
   - d. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

Clinical Criteria for Medical Management Decision Making

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

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to medical necessity clinical criteria for the evaluation and treatment of specific conditions and evolving medical technologies and procedures. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/ program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information.

Clinical polices do not constitute a description of plan benefits nor can they be construed as medical advice. These policies provide guidance as to whether or not certain services or supplies are cosmetic, medically necessary or appropriate, or experimental and investigational. The policies do not constitute authorization or guarantee coverage for a particular procedure, device, medication, service, or supply. In the event a conflict of information is present between a clinical policy, member benefits, legal and regulatory mandates and requirements, Medicare or Medicaid (as applicable) and any plan document under which a member is entitled to covered services, the plan document and regulatory requirements take precedence. Plan documents include, but are not limited to, subscriber contracts, summary plan documents and other coverage documents.

Clinical policies may have either a Health Net Health Plan or a “Centene” heading. Health Net utilizes InterQual® criteria for those medical technologies, procedures or pharmaceutical treatments for which a specific health clinical policy does not exist. InterQual is a nationally recognized evidence-based decision support tool. Clinical policies are reviewed annually and more frequently as new clinical information becomes available.

Continuity of Care

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

Health Net provides for continuity of care (COC) for new and existing members due to termination of prior coverage and any health plan withdrawn from any portion of the market for a currently enrolled Health Net member. Health Net members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months.

A current member may also request COC to complete care with a departing Health Net provider after that provider leaves Health Net's network. Covered services are provided for the period of time necessary to complete a course of treatment and to arrange for safe transition of care to another provider. Health Net makes the decision in consultation with the member and the terminated provider or nonparticipating provider, and consistent with good professional practice.

Continuity of Care

Member requests for COC assistance must meet certain criteria:

- There are no documented quality-of-care issues, or state or federal exclusion requirements where Health Net has determined the provider is ineligible to continue providing services to Health Net members.
- Compensated rates and methods of payment are the same as those currently used by Health Net or the participating physician group (PPG) unless a letter of agreement or letter of understanding is executed.
- Copayments, deductibles or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same the member would pay if receiving care from a provider currently contracting with Health Net.

Types of clinical criteria where a member may be eligible for COC

- Acute condition – a sudden onset of symptoms due to an illness, injury, or other medical problem.
- Serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder, not to exceed 12 months from the member's effective date of coverage.
- Pregnancy – for the duration of the pregnancy and the immediate postpartum period.
    - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri- or post-partum, or that arises during pregnancy, in the peri- or post-partum period, up to one year after delivery.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. COC applies for the duration for the terminal illness.
- Newborn care – birth to 36 months, not to exceed 12 months from the member's effective date of coverage under the plan.
- Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
- Behavioral health conditions – all acute, serious or chronic mental health conditions, including treatment for children diagnosed with autism spectrum disorder (ASD). These services include applied behavioral analysis (ABA) – for up to 12 months.

Exceptions

Some of the circumstances where COC is not available are:

- Services that are not a covered benefit of the plan.
- Out-of-network provider does not agree to Health Net's utilization management (UM) policies and payment rates.
- Provider type or service is for durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

Requesting Continuity of Care

New and existing members, their authorized representatives on file with Health Net, or their providers may request COC directly from Health Net. Refer to the Health Net Member Services Department for assistance.

Health Net reviews and completes COC requests within five business days after receipt of the request. When additional clinical information is necessary to make a decision, the COC request can be pended for an additional 45 days. The pend letter for the required information is generated and faxed to the requested provider. A hard copy will follow by mail to the provider and the member.

If there is an imminent and serious threat to the member's health, requests are completed within three calendar days.

Upon completion of the COC review, the provider and the member will be notified of the decision within 24 hours of the decision.

Applies to EPO and PPO members only: Health Net accepts and approves retroactive requests for COC that meet all requirements. The services must have occurred after the member's enrollment in the plan and Health Net must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the plan.

Out-of-network providers cannot refer the member to another out-of-network provider without authorization from Health Net or a delegated PPG.

PPG Process

Health Net forwards the COC request to the delegated PPG's UM department if the PPG termed the requested provider. The delegated PPG:

- Works with the out-of-network provider to secure a care plan for the member
- Makes the decision whether to extend the COC services, or to redirect the services in-network.
- Works with the out-of-network provider to make sure they are willing to work with the PPG and Health Net.

Economic Profiling

Provider Type: Physicians | 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.

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.
- 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.

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

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).
- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number.
- For obstetrical (OB) delivery admissions, include newborn sex, weight, apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

On receipt of admission notification, authorized services are entered into the Health Net's notification system and a tracking number is created and provided to the reporting party. The tracking number is also transferred electronically to the Health Net claims processing system.

The tracking number is not an authorization that services are covered under a member's benefit plan.

Telephone coverage is provided 24 hours a day, seven days a week for non-participating facilities reporting post-stabilization. Note: plans for which Department of Managed Health Care (DMHC) provides oversight (HMO, POS, Elect, Elect Open Access) have telephone coverage 24 hours a day, seven days a week for non-participating facility requests for prior authorization of services for patients deemed stabilized.

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

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

Wellcare By Health Net Medicare Dual Special Needs (D-SNP)

Per the State Medicaid Agency Contract (SMAC) with Department of Health Care Services (DHCS) contracted hospitals and SNFs must use one of the following methods, in a timely manner, to inform the member's D-SNP and the Medi-Cal plan of any hospital or SNF admission, transfer or discharge. Hospitals and SNFs must use either:

- A secure email or data exchange through a Health Information Organization or,
- An electronic process approved by DHCS.

This information must be shared to the extent allowed, under applicable federal and state law and regulations, and not be inconsistent with the member's expressed privacy preferences.

Contracted hospital	Must notify the D-SNP member's MCP either immediately prior to, or at the time of, the member's discharge or transfer from the hospital's inpatient services, if applicable.
Contracted SNFs	Must notify the D-SNP member's MCP within 48 hours after any SNF admission. For discharges or transfers, SNFs must notify the D-SNP member's MCP in advance if possible, or at the time of the member's discharge or transfer from the SNF

Facilities can identify the member's Medi-Cal plan by using the State online eligibility system (AEVS).

Utilization Management Goal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The goal of the Health Net Utilization Management (UM) and care management (CM) programs is to provide members with access to the health services delivery system in order to receive timely and necessary medical care in the correct setting. Health Net's UM and CM programs comply with all applicable federal and state laws, regulations and accreditation requirements. The UM system is also intended to analyze and measure effectiveness while striving for improvement of services. Health Net's UM system separates medical decisions from fiscal and administrative management to assure that medical decisions are not unduly influenced by fiscal and administrative management.

Health Net gathers encounter data from participating physician groups (PPGs) (if applicable) and data from the Health Net Medical Management System to monitor potential indicators over- and under-utilization. Based on the classification of delegation, the following types of data are collected:

- System-wide data:
  - Member services complaints
  - Member satisfaction surveys

- PPG transfer rates
- PPG data:
  - Encounter data
  - Unity system reports (such as Monthly Census and Detail reports)
  - PPG report card (profile reports of utilization statistics)
  - UM denial and appeal logs

Contacts in Alphabetical Order

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

- AcariaHealth
- Access to Interpreter Services
- American Specialty Health Plans
- Animas Diabetes Care, LLC
- Apria Healthcare, Inc
- ATG Rehab Specialists, Inc

B

Behavioral Health Provider Services

C

- Case Management Department
- 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.

F

G

H

- Health Net Care Management Department
- Health Net Credentialing Department
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Elect Claims
- Health Net Fraud Hotline
- Health Net's Health and Wellness Referral Fax
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Mail Order Prescription Drug Program
- Health Net 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

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

S

T

- Transitional Care Services
- Transplant Team
- TurningPoint Healthcare Solutions, LLC

U

V

W

X

Y

Z

Glossary

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)

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)

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)

W

X

Y

Z