Provider Manual - Combined

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

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Provider Manual

The 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 and Practitioners, 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 | Hospitals | Participating Physician Groups (PPG) | 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.

Prevent

Addressing trauma in primary care pediatrics can help patients 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. Note, only the ACEs questionnaire and PEARLs (Pediatric ACEs and Related Life Events Screener) are eligible for Medi-Cal reimbursement.

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
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

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 Health Net's behavioral health Case Management Department.

Health Net Community Connect

Health Net Community Connect is powered by Findhelp, 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

Medi-Cal providers who have completed the two-hour online ACEs training and submitted their self-attestation to DHCS can bill for ACE screenings.

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 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
- Acknowledgement and Resolution
- Dispute Submission
- Inquiry Submission

Overview

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

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

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim
- Challenge a request by Health Net for reimbursement for an overpayment of a claim
- Seek resolution of a billing determination or other contractual dispute with Health Net
- Appeal a written determination when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the written determination

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

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

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

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

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

For additional information refer to Definition of Contracted Provider Dispute..

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.

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 Grievances Department.

Health Net acknowledges receipt of the grievance within five calendar days and sends a final resolution/ disposition letter to the member within 30 calendar days for HMO and PPO members. If the case exceeds the 30-day 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). To access an online member grievance form, visit the following websites:

- Ambetter Individual & Family Plans
- Commercial Employee Group Plans

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 Collaboration Effort (HICE) website at www.ICEforhealth.org > Library > Final HICE Documents > Health Equity Team folder. For additional information, providers can contact the Health Equity 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 Health Equity Department.

Benefits

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

This section contains general member benefit information.

Benefits in Alphabetical Order

Select any subject below:

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

A

- Acupuncture
- Alcohol and Drug Abuse
- Allergy Treatment
- Ambulance
- Autism Spectrum Disorders

B

- Bariatric Surgery
- Behavioral Health
- Blood

C

- Clinical Trials
- Cosmetic and Reconstructive Surgery

D

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

E

- Essential Health Benefits

F

- Family Planning

G

- General Benefit Exclusions and Limitations
- Genetic Testing

H

- Hearing
- Home Health Care
- Hospice Care
- Hospital and Skilled Nursing

I

- Immunizations
- Incarcerated Members

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

- Sensitive Services - Rape and Sexual Assault
- Support for Disabled Members
- Surgery, Surgical Supplies and Anesthesia

T

- TMJ
- Transgender Services
- Transplants
- Tuberculosis Screening

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

Services, laboratory tests, X-rays and other treatment not approved by American Specialty Health Plans, Inc. (ASH Plans) and documented as medically/clinically necessary as appropriate or classified as experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If a member has a life-threatening or seriously debilitating condition and ASH Plans denies coverage based on the determination that the therapy is experimental, they may be able to request an independent medical review of ASH Plans' determination. The member can contact ASH Plans for more information.

Additional exclusions and limitations include, but are not limited to, the following:

- **Auxiliary aids** - Auxiliary aids and services are not covered. This includes but is not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- **Diagnostic radiology** - No diagnostic radiology (including x-rays, magnetic resonance imaging or MRI) is covered.
- **Drugs** - Prescription drugs and over-the-counter drugs are not covered.
- **Durable medical equipment** - Durable medical equipment is not covered.
- **Educational programs** - Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.
- **Experimental or investigational acupuncture services** - Acupuncture care that is (a) investigatory; or (b) an unproven acupuncture service that does not meet generally accepted and professionally recognized standards of practice in the acupuncture provider community is not covered. ASH Plans will determine what will be considered experimental or investigational.
- **Hospital charges** - Charges for hospital confinement and related services are not covered.
- **Anesthesia** - Charges for anesthesia are not covered.
- **Hypnotherapy** - Hypnotherapy, sleep therapy, behavior training and weight programs are not covered.
- **Noncontracted providers** - Services or treatment rendered by acupuncturists who do not contract with ASH Plans are not covered, except with regard to emergency acupuncture services or upon referral by ASH Plans.
- **Acupuncture services not listed under acupuncture services in the EOC** - Only acupuncture services that are listed under "Acupuncture Services" in the EOC are covered. Unlisted services, which include, without limitation, services to treat asthma and services to treat any addiction, including treatment for smoking cessation, are not covered.
- **Out-of-state services** - Services provided by an acupuncturist practicing outside California are not covered, except with regard to emergency acupuncture services.
- **Thermography** - The diagnostic measuring and recording of body heat variations (thermography) are not covered.
- **Transportation costs** - Transportation costs are not covered, including local ambulance charges.
- **X-ray and laboratory tests** - X-ray and laboratory tests are not covered.
- **Medically/clinically unnecessary services** - Only Acupuncture Services that are necessary, appropriate, safe, effective and that are rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

- **Services not within license** - Only services that are within the scope of licensure of a licensed acupuncturist in California are covered. Other services, including, without limitation, ear coning and Tui Na are not covered. Ear coning, also sometimes called “ear candling,” involves the insertion of one end of a long, flammable cone (“ear cone”) into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called “Oriental Bodywork” or “Chinese Bodywork Therapy,” utilizes the traditional Chinese medical theory of *Qi* but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.
- **Vitamins** - Vitamins, minerals, nutritional supplements or other similar products are not covered.

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
- Parity Cost Shares
- Substance Abuse Facilities
- Substance Abuse Rehabilitation Services
- Minor's Consent for Services

Overview

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

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

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

Exclusions and Limitations

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

Parity Cost Shares

Provider Type: Participating Physician Groups (PPG) | Hospitals

Capitated/delegated participating physician groups and capitated/delegated hospitals must ensure claims payments for applicable services comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and related final rule.

Benefit and cost share for behavioral health services

Behavioral health benefits must incorporate the **primary** diagnosis and procedure code as a primary driver for benefit categorization and cost share application. These changes result in additional services applying a behavioral health cost share, where previously they would have applied a medical cost share. Examples include, but are not limited to, the following:

- **Example 1**: A primary care physician who bills for an office visit with a primary behavioral health diagnosis code will apply a Mental Health Office Visit cost share.
- **Example 2**: Outpatient habilitative therapy session billed with a primary behavioral health diagnosis will apply the Mental Health Outpatient-Other cost share.
- **Example 3:** Inpatient facility services are driven by the bed type (revenue code) billed on the claim. A mental health bed-type revenue code will apply the Mental Health Inpatient benefit and cost share.

- **Example 4:** Gender affirming **surgery** performed in an inpatient setting and billed with a primary mental health diagnosis (i.e., gender dysphoria) will apply the Mental Health Inpatient benefit and cost share instead of the medical surgery benefit and cost share.
- **Example 5:** Diagnostic radiology services billed with a primary behavioral health diagnosis will apply the Mental Health Outpatient-Other benefit and cost share, instead of the medical radiology benefit cost share.
- **Example 6:** Physical, occupational and/or speech therapy billed with a primary behavioral health diagnosis (e.g., autism) will apply the Mental Health Outpatient-Other benefit and cost share, instead of the medical PT/OT/ST cost share.

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.

Rediagnosis for Continued Treatment

Effective January 1, 2026, per Assembly Bill 951, a member is not required to obtain a rediagnosis who has previously been diagnosed with pervasive developmental disorder or autism to maintain coverage for behavioral health treatment.

This does not prevent a treating physician or other provider from reevaluating a member or prescribing a rediagnosis for purposes of determining the appropriate treatment. The treatment plan shall be made available to Health Net upon request.

Benefit coverage for treatment cannot be discontinued or delayed while waiting for a rediagnosis to be completed. This does not restrict Health Net from requiring a utilization review which is not the same as a rediagnosis.

A rediagnosis means:

- A subsequent undertaking by any method, device, or procedure, whether gratuitous or not, to ascertain or establish if a person is suffering from a physical or mental health disorder, pursuant to Section 2038 of the Business and Professions Code. “Rediagnosis”also means prescription of a subsequent diagnosis of pervasive developmental disorders or autism to ascertain or establish if a person is suffering from a pervasive developmental disorder or autism.

Utilization review means:

- Utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians licensed pursuant to Chapter 5

(commencing with Section 2000) of Division 2 of the Business and Professions Code before, after, or concurrent with the provision of medical treatment services. “Utilization review” refers to an evaluation of existing treatment to ensure the insured receives the proper care at the proper time.

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

ABA Forms

- Applied Behavioral Analysis (ABA) Prior Authorization Request Form (PDF) – ABA treating practitioners are required to submit a prior authorization request form along with an updated treatment plan to Health Net prior to delivering ABA services.
- Confirmation of Diagnosis: Autism Spectrum Diagnosis (ASD) Form (PDF) – This form must be completed by a licensed physician or licensed psychologist to establish a diagnosis of autism and recommend ABA services. Attach a copy of the member’s most recent face-to-face evaluation and any additional supporting documentation (e.g., comprehensive diagnostic evaluation, prescription, physician letter, etc.)

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 – Prior Authorization.

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 or substance abuse care services.

Select any subject below:

- Overview
- Behavioral Health Customer Service
- Coordination of Care
- Day Care Treatment
- Dual Diagnosis
- Employee Assistance Program
- Exclusions
- General Guidelines for Referrals
- Management of Outpatient Services
- Minors and/or Adults Unable to Give Consent
- Obtaining Behavioral Health or Substance Abuse Care
- Out-of-Area Cases Involving an Acute Medical Diagnosis
- Parity Cost Shares

Overview

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

Health Net manages inpatient and outpatient treatment for behavioral health or 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 or 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 or 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 or 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.

Refer to the following Behavioral Health definition in the glossary for more information.

- Mental health application information
- Mental Health Digital Services

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

Management of Outpatient Services

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

Health Net uses analytics to identify providers who may have practice patterns that are at significant variance to Health Net expected treatment norms.

“Exception” reports are regularly generated for Health Net management review. If the manager identifies practice patterns that suggest variance from clinically accepted guidelines, these practitioner/member combinations are assigned to a licensed Utilization Manager for clinical review. The Utilization Manager does a full review of case notes and member history to better understand the clinical situation and history of treatment. If, based on the clinical aspects of the case, the Utilization Manager decides that no further intervention is required, they will consider the review complete. If further discussion is indicated, they will contact the practitioner for a discussion of the member’s clinical status, current signs and symptoms, the practitioner’s goals and milestones of treatment, and how the current treatment plan is designed to meet these goals.

Health Net has found that in most cases, practitioners are very open to a collegial, collaborative discussion and often will accept the Utilization Manager’s offer of assistance; for instance, to arrange for a medication evaluation, or an adjustment in the treatment plan with an agreement to review again at a later, mutually established time.

In those infrequent cases in which there are ongoing concerns after contacting the provider, the Utilization Manager will consult with a Health Net medical director to determine the next steps. Health Net has found that due to this collaborative process with practitioners, a need for further corrective action is rarely required. Overall, this process has been very well received by the provider community.

Minors and/or Adults Unable to Give Consent for Treatment; Consent For Release of Information

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

Health Net and its contracted practitioners have a responsibility to recognize and help protect the rights of minors and adults unable to give consent. When consent for “Release of Information” or treatment is necessary for members who are minors or adults unable to give consent, the practitioner should obtain written consent from a parent, legal guardian, or other appropriate individual or agency.

The completed consent for treatment or “Release of Information” form should be in the practitioner’s treatment record. When practitioner treatment records are audited against treatment record standards, consents should be present when records pertain to members who are minors or adults unable to give consent. For additional information refer to:

- Access to Care and Availability Standards (HMO)
- Access to Care and Availability Standards(PPO)
- Access to Care and Availability Standards (Medi-Cal, CalViva Health, CHPIV)
- Access to Care and Availability Standards (Medicare)

Obtaining Behavioral Health or 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.

Health Net does not require authorization for routine in-network outpatient services. Covered routine outpatient services include, but are not limited to:

- Psychiatric diagnostic interview
- Individual therapy
- Family therapy
- Group therapy
- Medication management

Psychological and neuropsychological testing are covered services in most benefit plans. Prior authorization is required for psychological and neuropsychological testing. Prior authorization is also required for Applied Behavior Analysis (ABA) Services.

Authorization requests can be submitted by calling the Health Net Behavioral Health call center and obtaining an authorization request form, which can subsequently be submitted by fax or email. For additional information refer to the Prior Authorization section.

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.

Parity Cost Shares

Provider Type: Participating Physician Groups (PPG) | Hospitals

Capitated/delegated participating physician groups and capitated/delegated hospitals must ensure claims payments for applicable services comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and related final rule.

Benefit and cost share for behavioral health services

Behavioral health benefits must incorporate the **primary** diagnosis and procedure code as a primary driver for benefit categorization and cost share application. These changes result in additional services applying a behavioral health cost share, where previously they would have applied a medical cost share. Examples include, but are not limited to, the following:

- **Example 1**: A primary care physician who bills for an office visit with a primary behavioral health diagnosis code will apply a Mental Health Office Visit cost share.
- **Example 2**: Outpatient habilitative therapy session billed with a primary behavioral health diagnosis will apply the Mental Health Outpatient-Other cost share.
- **Example 3:** Inpatient facility services are driven by the bed type (revenue code) billed on the claim. A mental health bed-type revenue code will apply the Mental Health Inpatient benefit and cost share.
- **Example 4:** Gender affirming **surgery** performed in an inpatient setting and billed with a primary mental health diagnosis (i.e., gender dysphoria) will apply the Mental Health Inpatient benefit and cost share instead of the medical surgery benefit and cost share.
- **Example 5:** Diagnostic radiology services billed with a primary behavioral health diagnosis will apply the Mental Health Outpatient-Other benefit and cost share, instead of the medical radiology benefit cost share.

- **Example 6:** Physical, occupational and/or speech therapy billed with a primary behavioral health diagnosis (e.g., autism) will apply the Mental Health Outpatient-Other benefit and cost share, instead of the medical PT/OT/ST cost share.

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
- Cleft Palate Diagnoses

Breast Cancer Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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)

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
- Exclusions and Limitations
- Orthotics
- Service Providers

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 | Ancillary| Participating Physician Groups (PPG)

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

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

Service Providers

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

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

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

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

For blood pressure monitors and cuffs, use the Blood Pressure Monitor Request Form (Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley) and fax it to our preferred DME vendor, Western Drug.

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.

Doula Services

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

This section contains general information on doula services. Doula services strive to prevent perinatal complications and improve health outcomes for birthing parents and infants.

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

Eligibility requirements

- The member must be active and enrolled with Health Net.
- The member must be pregnant or have been pregnant within the past 12 months and would benefit from doula services.

Doula programs available

Members are offered a choice between two doula programs at no cost. A member may choose support under the Individual Doula Program or the Mahmee Virtual Doula Program, but not both.

1. **Individual doula services** – Members can receive doula services in person or virtually during the pregnancy in any setting, such as home, office hospital, or an alternative birthing center. Services include but are not limited to:

- An initial visit.
- Up to eight additional visits, including pre- and post-birth visits. All visits are limited to one per day, per member.
- Support during labor and birth.
- Up to two additional visits after birth to discuss breast feeding, mental health, and other concerns. Visits may last up to three hours.

How to find a doula

Call Health Net Provider Services 24 hours a day, 7 days a week:

2. **Mahmee virtual doula**

Mahmee offers virtual doula services via the Mahmee mobile app that is designed to better connect new moms with health care and support. Enrolled members get access to their digital program and access to a team of experts (wrap-around maternity support team) that includes doulas, registered nurses, lactation consultants,

mental health coaches, nutrition coaches, infant feeding specialists and care coordinators. Providers connected to the Mahmee system can receive shared information. Services include but not limited to:

- Initial intake visit.
- Unlimited prenatal visits.
- Support during labor and birth.
- Up to two extended in-person postpartum visits (where available). Visits may last up to three hours.
- Members may work with one or more doulas during virtual and in-person visits.
- Mahmee offers in-person visits in select counties based on availability. Physicians and other providers can refer members to Mahmee directly to check availability of a doula in their county or contact the Health Net Member Services listed on the back of their member identification card.

Mahmee app

The digital platform gives the member access to one-on-one virtual visits, group chats, individual and group classes, coaching, and direct messaging. Plus, access to articles and videos.

How to enroll with Mahmee

Physicians and other providers can inform members to call Member Services. The number is on the back of their medical identification card. Members can also call Mahmee directly or register online at https://www.mahmee.com/ and select eligibility.

Note, a member may receive individual doula services or Mahmee virtual doula with wrap-around support, but not both.

Assistive services during visits

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

Coordinating services

Doulas and Mahmee should work with the member’s primary care physician or obstetrician and contact Health Net if the members need additional support.

- Doulas do not replace a doctor or the care provider and do not provide medical advice.
- Mahmee is not a network of doctors. They do not replace the member’s current doctors or care providers. They act as a liaison between the member, doctor and their care team.

Non-covered doula services

The following are not covered under doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)

- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

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 or 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

health net

Overview

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

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 member.

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). Before beginning infertility treatment, the member's treating provider 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 provider 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 - All plans cover IVF or ZIFT. Refer to the Schedule of Benefits for specific plan information

Refer to the Schedule of Benefits 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. Applicable deductible or copayment requirements apply to any services and supplies required for Iinfertility services. For example, if the infertility service requires an office visit, then the office visit copayment will apply.

The required copayments for infertility procedures 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 the:

- 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)

Infertility means a condition or status characterized by any of the following:

1. A licensed physician's findings, based on a patient's medical, sexual, and reproductive history; age; physical findings; diagnostic testing; or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in item 3 below.
2. A person's inability to reproduce either as an individual or with their partner without medical intervention.
3. The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under age 35 years or no more than 6 months of unprotected sexual intercourse for a person age 35 years or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Infertility services is a required benefit for large employer group plans and an optional benefit for small employer group plans. When Health Net covers 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 and diagnostic tests.
- Artificial insemination (AI), intrauterine insemination (IUI) and gamete intrafallopian transfer (GIFT). Some custom employer group plans include coverage of assisted reproductive technologies (ART), in vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT).
- Covered services include:
  - Prescription drugs.
  - Professional services
  - Inpatient and outpatient care.
  - Treatment by injections.
- Infertility prescription drugs are subject to the applicable Tier 1, 2 or 3 drug copayments as listed in the member's Schedule of Benefits.

Note: Large group plans can be in the Specialty Tier and small groups can be in Tier 4.

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 completed oocyte retrieval cycles 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

IUI 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 the:

- 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 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

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 (maximum of three completed oocyte retrievals).
- Culture and fertilization of the oocyte.
- Embryo transfer – unlimited.

A cycle is counted toward the lifetime maximum once the member has had their 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. Applicable deductible or copayment requirements apply to any services and supplies required for infertility services. For example, if the infertility service requires an office visit, then the office visit copayment will apply.

The required copayments for infertility procedures apply to the 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.
- 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, 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) | Hospitals | Ancillary

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in the Evidence of Coverage (EOC).

These exclusions and limitations do not apply to medically necessary basic health care services required to be covered under California or federal law, including but not limited to medically necessary treatment of a mental health or substance use disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

- 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, supplies or surgeries - The Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in the EOC, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in the EOC, or as required by law. This exclusion does not apply to the following:
    - Medically necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
    - Reconstructive surgery as described in the EOC.
    - For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the EOC.
- 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 - The Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in the EOC or as required by law. This exclusion does not apply to the following:
    - Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
    - Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
    - Custodial care provided in a health care facility.

- Dental services This Plan does not cover dental services or supplies, except as described in the EOC as required by law.
- 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 for home use - The Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in the EOC or as required by law.
- Experimental services or investigational services – The Plan does not cover experimental services or investigational services, except as described in the EOC or as required by law.

Experimental devices means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental services are not undergoing a clinical investigation.

Investigational services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not in wide usage.

The determination that a service is an experimental service or investigational service is based on:

1. Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
2. Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
3. Reference to current medical literature.



However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a life-threatening or seriously debilitating condition.
2. Your health care provider must certify to the Plan that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your health care provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the health care provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your health care provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an experimental service or investigational service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your health care provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

Department of Managed Health Care's (DMHC's) Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a member's rights to an IMR from the DMHC as described in the EOC. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for experimental services or investigational services. In such cases you may immediately contact the DMHC to request an IMR of this denial.

- Vision care - The Plan does not cover vision services, except as described in the EOC or as required by law.
- 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 – The Plan does not cover hearing aids, except as described in the EOC or as required by law.
- 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– The Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
- Private-duty nursing – The Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in the EOC or as required by law.
- 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 voluntary surgical sterilization - The Plan does not cover reversal of voluntary sterilization, except for medically necessary treatment of medical complications, except as described in the EOC or as required by law.
- Routine physical examinations The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described under the EOC as required by law. 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, supplies or surgeries - The Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in the EOC, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in the EOC, or as required by law. This exclusion does not apply to the following:
    - Medically necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
    - Reconstructive surgery as described in the EOC.
    - For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the EOC.

- 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 - The Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in the EOC or as required by law. This exclusion does not apply to the following:
    - Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
    - Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
    - Custodial care provided in a health care facility.

- Dental services - This Plan does not cover dental services or supplies, except as described in the EOC as required by law.
- 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 for home use - The Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in the EOC or as required by law.
- Experimental services or investigational services – The Plan does not cover experimental services or investigational services, except as described in the EOC or as required by law.

Experimental devices means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental services are not undergoing a clinical investigation.

Investigational services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not in wide usage.

The determination that a service is an experimental service or investigational service is based on:

1. Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
2. Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
3. Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a life-threatening or seriously debilitating condition.
2. Your health care provider must certify to the Plan that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your health care provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the health care provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your health care provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an experimental service or investigational service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your health care provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

Department of Managed Health Care's (DMHC's) Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a member's rights to an IMR from the DMHC as described in the EOC. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for experimental services or investigational services. In such cases you may immediately contact the DMHC to request an IMR of this denial.

- Vision care - The Plan does not cover vision services, except as described in the EOC or as required by law.
- 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 - The Plan does not cover hearing aids, except as described in the EOC or as required by law.
- 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 - The Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
- Private-duty nursing - The Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in the EOC or as required by law.
- 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 voluntary surgical sterilization - The Plan does not cover reversal of voluntary sterilization, except for medically necessary treatment of medical complications, except as described in the EOC or as required by law.
- Routine physical examinations- The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described under the EOC as required by law.
- 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) | 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) | 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) | 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 health care, 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. Note, the form should not be submitted for Medicare Individual Plan members.

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 are required to screen for maternal mental health conditions once during pregnancy and once within the first six weeks postpartum. Additional screenings must be offered if determined to be medically necessary and clinically appropriate.

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 Medi-Cal 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 the Plan's Case Management Department for further assistance with the member's mental health needs.

Notice of Pregnancy

Let us know about a member’s pregnancy so they can receive personalize care. Complete the Notification of Pregnancy form and fax it to the number on the form. This helps the member and their baby get the best care possible.

- Provider Notification of Pregnancy (PDF)
- Provider Notification of Pregnancy - CalVIva Health (PDF)
- Provider Notification of Pregnancy - CHPIV (PDF)

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.

A pregnancy program is available 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)

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)

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)

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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

Obesity is defined as an excess of body fat. Body mass index (BMI) is a measure of body weight relative to height. BMI can be used to determine if people are at a healthy weight, overweight or obese. An adult member whose BMI is 25 to 29.9 is considered overweight and a BMI of 30 or more is considered obese. Children of

the same age and sex, with a BMI at or above the 85th percentile and lower than the 95th percentile is defined as overweight. Considerations for obesity is having a BMI at the 95th percentile or above.

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

Coverage

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

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

The following information does not apply to Medi-Cal

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

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

For more information, select the subject below:

Bariatric Surgery Services (HMO and PPO only)

Bariatric Surgery Services

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

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

Outpatient Services

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

This section contains general member benefit information on outpatient services.

Select any subject below:

- Coverage Explanation

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, 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.

Sensitive Services - Rape and Sexual Assault

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

Rape and sexual assault could also be inferred as “intimate partner violence” and would also be identified as a sensitive service.

SECTION 1. Section 56.05 of the Civil Code is amended to read:**56.05.** For purposes of this part:(n) “Sensitive services” means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Coverage

Health Net covers emergency room care and follow-up medical treatment without any member cost share for members who have suffered rape or sexual assault.

Members may obtain any of the following services for rape or sexual assault without any member cost share from the start of treatment (members enrolled in a high deductible health plan (HDHP) are subject to plan deductible):

- Emergency room care.
- Follow-up treatments, including any medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault.
- Mental health treatments.
- Out-of-network services if medically necessary care is not available within the member’s network.

How to bill for services

Providers may use standard diagnosis codes recognized by Health Net that pertain to rape or sexual assault following Billing and Submission requirements. Health Net requires that the ICD-10 Dx code is visible on the face of the paper-based prescription when pharmacist is filling the prescription. For electronic scripts, providers are responsible for determining where to place this information, based on their Electronic Medical Record (EMR) system.

If you have questions on how or where to place the Dx code, please contact your EMR vendor for information. Please note that any prescriptions given for member care will need to include the relevant diagnosis code(s).

Support for Disabled Members

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

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

Select any subject below:

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

Americans with Disabilities Act of 1990

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

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

Auxiliary Aids and Services

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

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

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

Effective Communication

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

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

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

Financial Responsibility

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

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

Undue Burden

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

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

Surgery, Surgical Supplies, and Anesthesia

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

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

Select any subject below:

- Coverage Explanation
- 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 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 members for a transplant procedure.

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

Tuberculosis Screening

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

Screening for members ages 18 and older

Members ages 18 and older can be offered TB screening assessments if risk factors are identified using the following criteria:

- Adult members who receive primary care services in a facility, clinic, center, office, or other setting where primary care services are provided, **shall be offered a TB risk assessment and TB screening test**, if TB risk factors are identified, based on the latest screening indications recommended by the U.S. Preventive Services Task Force, unless the provider reasonably believes that one of the following conditions applies:
    - The member is being treated for a life-threatening emergency.
    - The member has previously been offered or has been the subject of a TB risk assessment, TB screening test, or both, and has no new TB risk factors since the last TB risk assessment or TB screening test, unless the provider determines that they should be offered again.
    - The member has a documented, previously positive Interferon-Gamma Release Assays test or has previously tested positive for a latent tuberculosis infection (LTBI).
    - The member lacks capacity to consent to the assessment or test and/or consent cannot be obtained from a person legally authorized to make medical decisions on the patient's behalf.
    - The member is being treated in the emergency department of a general acute care hospital.
- If a member accepts the offer of the TB screening test and the test is positive, providers are required to offer the member follow-up care or refer the member to a provider who can provide follow-up care.

For more information on TB reporting and care management, refer to the Communicable Diseases and Reporting section.

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 member 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 provider are Health Net's preferred provider for laboratory services for the following lines of business:

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

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

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

- Electronic prescription capability to order and renew prescriptions.
- Patient-friendly reports that help easily explain test results.

Radiation Therapy

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

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

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

Claims and Provider Reimbursement

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

This section describes claims and provider reimbursement

Select any subject below:

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

Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

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

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

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

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 Provider Portal

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

To view and submit claims, log in to one of the following provider portals

Availity	Health Net
1. Log in, then go to *Claims & Payments* section from the main menu. 2. Select *Submit a Claim* or *Claim Status*.	1. Log in, then select the applicable line of business from the drop-down menu > *Go*. 2. Once you have checked the member's eligibility, select *Claims* located in the left-hand column. 3. Select the green *Create a New Claim* button to begin a new claim for this member.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website (HMO/PPO/Health Net Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley, Wellcare By Health Net) for details on what functions can be accessed through each portal.

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
- Claims Submission
- Claims Submission Requirements
- Clinical Information Submission
- CMS-1500 Billing Instructions
- Critical Access Hospitals Requirement
- Health Savings Account
- Hospital Acquired Conditions
- Trauma Services
- UB-04 Billing Instructions

- Workers' Compensation

Claims Receipt Acknowledgement

Provider Type: Physicians | Ancillary | Hospitals

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

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

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

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

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

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

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

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

Claims Rejection Reasons and Resolutions

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

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

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

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

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

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

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

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

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

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

The documentation of each patient encounter should include the following:

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

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

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

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

CMS-1500 Billing Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Critical Access Hospitals Requirement

Provider Type: Hospitals

Critical Access Hospitals contracted with Health Net for the Individual and Family Plans (IFP), including Ambetter HMO and Ambetter PPO, and Employer Group HMO, POS and PPO lines of business must use the correct **Type of Bill (TOB)** when submitting claims, based on the service type.

Claims submitted with an incorrect TOB will be denied.

Denied claims must be corrected and resubmitted with the appropriate TOB to be reconsidered for payment. Follow the steps below for appropriate submission:

1. Review your current claim submission processes.
2. Verify that claims are submitted with the correct TOB.
3. Update billing system configurations, if needed, to support accurate claim submissions.

Use the following TOB designations when submitting claims for Ambetter HMO and Ambetter PPO:

Service Type	Type of Bill
Inpatient hospital services	11X
Outpatient hospital services	85X
Laboratory services	14X
Swing bed services	18X
Other services	As applicable, based on Centers for Medicare & Medicaid Services (CMS) and contractual billing requirements

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

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Unlabeled field	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state, and ZIP +4 Codes (include hyphen). Note: The 9 digit ZIP (ZIP +4 codes) is a requirement for paper and EDI claims. Line 4: Enter the area code and telephone number **ALERT: Providers submitting paper claims should left-align data in this field.	Required
2	Unlabeled field	Enter the pay-to name and address	Not required

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address.	
9	Patient address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (NOT REQUIRED)	Required - Except line 9e county code
10	Birthdate	Enter the patient's date of birth (MMDDYYYY)	Required - Ensure DOB of patient is entered and not the insured)
11	Sex	Enter the patient's sex. Only M or F is accepted	Required
12	Admission date	Enter the date of admission for inpatient claims and date of service for outpatient claims (MMDDYY)	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.

Field number	Field description	Instruction or comments	Required, conditional or not required
13	Admission hour	Enter the time using two-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a..m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.
14	Admission type	Require for inpatient and outpatient admissions. Enter the one-digit code indicating the type of the admission using the appropriate following codes: • 1 - Emergency	Required

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: • 01 - Routine discharge • 02 - Discharged to another short-term general hospital • 03 - Discharged to SNF • 04 - Discharged to ICF • 05 - Discharged to another type of institution • 06 - Discharged to care of home health service organization • 07 - Left against medical advice • 09 - Discharged/ transferred to home under care of a home IV provider • 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 20 - Expired or did not recover • 30 - Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown (hospice use only) • 43 - Discharged/ transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) • 50 - Hospice-Home • 51 - Hospice-Medical Facility • 61 - Discharged/ transferred within this institution to a hospital-based Medicare approved swing bed	

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility certified under Medicaid but not certified under Medicare • 65 - Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital • 66 - Discharged/ transferred to a critical access hospital (CAH)	
18-28	Condition codes	REQUIRED when applicable. Condition codes are used to identify conditions	Conditional REQUIRED when condition codes are

Field number	Field description	Instruction or comments	Required, conditional or not required
		relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual	used to identify conditions relating to the bill that may affect payer processing
29	Accident state	N/A	Not required
30	Unlabeled Field	N/A	Not required
31-34 a-b	Occurrence code and occurrence date	Occurrence code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		Occurrence span date: REQUIRED when applicable or when a corresponding occurrence span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYY format.	
37	Unlabeled field	REQUIRED for re-submissions or adjustments. Enter the DCN (document control number) of the original claim	Conditional REQUIRED for resubmissions or adjustments. Enter the DCN (document control number) of the original claim
38	Responsible party name and address	N/A	Not required
39-41 a-d	Value codes and amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).	Conditional REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
42 Lines 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value	
42 Line 23	Rev CD	Enter 0001 for total charges.	Required
43 Lines 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	Required
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim)	Conditional - Enter the number of pages. (Limited to 4 pages per claim)
44 lines 1-22	HCPCS/Rates	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters.	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service

Field number	Field description	Instruction or comments	Required, conditional or not required
		Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/ HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/ HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract	line revenue code billed
45 Lines 1-22	Service date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	Conditional REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
45 Line 23	Creation date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	Required

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
56	National Provider Identifier or provider ID	REQUIRED: Enter providers 10-character NPI ID	Required
57	Other provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider	Required
58	Insured's name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial	Required
59	Patient relationship	N/A	Not required
60	Insured unique ID	REQUIRED: Enter the patient's insurance ID exactly as it appears on the patient's ID card. Enter the insurance ID in the order of liability listed in field 50	Required
61	Group name	N/A	Not required
62	Insurance group no.	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
63	Treatment authorization code	Enter the prior authorization or referral when services require precertification	Conditional - Enter the prior authorization or referral when services require precertification
64	Document control number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line Applies to claim submitted with a type of bill (field 4), frequency of "7" (replacement of prior claim) or type of bill, frequency of "8" (void/cancel of prior claim). *Please refer to the reconsider/corrected claims section	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Payer from field 50
65	Employer name	N/A	Not required
66	DX version qualifier	N/A	Required
67	Principal diagnosis code	Enter the principal/ primary diagnosis or condition using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service	Required

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

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

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

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

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	Required
82	Attending Physician	Enter name or seven-digit provider number of ordering physician	Required

Workers' Compensation

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

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

- Providers must contact their PPG to check for any special billing requirements that the providers' failure to follow could delay the processing of their claims, and to verify the billing address for claims submission.
- Providers have 180 days from the last day of the month of service to submit initial Medi-Cal claims. Exceptions for late filing are:
- New Medi-Cal claims between six-months and one-year-old are permitted without penalty for unknown eligibility status, antepartum obstetric care or a delay in delivery of a custom-made prosthesis

- Claims one-year-old or more are permitted without penalty for retroactive eligibility situations, court orders, state or administrative hearings, county errors in eligibility, Department of Health Care Services (DHCS) orders, reversal of appeal decisions on a Treatment Authorization Request (TAR) form, or if other coverage is primary

Capitated-Risk Claims

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

Electronically Submitted Claims

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

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

Denied Claims

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

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

Members Notices About Incomplete Claims (applies only to HMO, PPO and Medi-Cal)

Claims received on or after January 1, 2026 must be reimbursed fully or partially within 30 calendar days of receipt. If a claim is incomplete, the physician or other provider must be notified as soon as possible, and no later than 30 calendar days after receiving the claim.

Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.

PPGs and hospitals delegated to pay claims must notify the member and provider in writing within 30 calendar days from receipt of the claim of an incomplete claim. Notices must specify:

- Date of denial notice.
- Member name.
- Provider name.
- Specific service.

- Date of service.
- Denied amount.
- Member responsibility amount.
- Reason for the denial - Claim denials for members must include a claim denial message.
- Provider and member appeals process and information, including plan name, address and telephone number for appeals.

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 PPG/IPA, Hospital or Ancillary provider."

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

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

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

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

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

Shared-Risk Claims

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

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

The following information must be included on every claim:

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

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

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

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

Anesthesia Procedure Code Modifiers with the Minute Qualifier

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

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

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

Use the MJ qualifier with these modifiers:

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

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

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

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).

Emergency-related Claim Submissions

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

In emergency-related situations whereby the Department of Health Care Services (DHCS) guidelines are silent regarding claims submission, Health Net will follow the Centers for Medicare & Medicaid Services (CMS) coding and billing guidelines to ensure compliance and consistency in our practices.

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
- Pharmacist Services
- Reimbursement Timelines and Penalties for Late Claims

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.

Reimbursement Timelines and Penalties for Late Claims

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

Claims received on or after January 1, 2026 must be reimbursed fully or partially within 30 calendar days of receipt. If a claim is incomplete, the physician or other provider must be notified as soon as possible, and no later than 30 calendar days after receiving the claim.

Interest and Penalty Payments for Late Claims

Late paid claims must include interest at the rate of 15% per annum beginning with the first calendar day after the 30-calendar day period.

Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.

Member Complaints

Member complains about a delay or denial of payment of a claim must be treated as a grievance, subject to Health Net's grievance process. Refer to the Grievances section below for more information.

Grievances (HMO)

Grievances (PPO)

Grievances (Medi-Cal)

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.

Policy Name	Clinical Policy Number	Description
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies.
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

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

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

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

Clinical Payment Policy Appeals

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

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.
4. How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.

6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. How the recommended service has been successful in other patients.

Compliance and Regulations

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

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

Select any subject below:

- Mandatory Data Sharing Agreement
- Reproductive Privacy Act
- Communicable Diseases Reporting
- DMHC-Required Statement on Written Correspondence
- Federal Lobbying Restrictions
- Health Net Affiliates
- Material Change Notification
- Nondiscrimination

Mandatory Data Sharing Agreement

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

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

Entities listed below are required to sign a data sharing agreement (DSA).

Participating required to sign a DSA include:

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities.
- Clinical laboratories.
- Acute psychiatric hospitals.
- Physician practices with 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.
- Nonprofit clinics with fewer than 10 health care providers.

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

Reproductive Privacy Act

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

Refer to Sensitive Services for complete information.

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

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

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

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

Health Net Affiliates

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

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

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

Material Change Notification

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

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

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

Nondiscrimination

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

The following nondiscrimination requirements apply.

Employment

The plan and its participating providers must comply with the provisions of the Fair Employment and Housing Act (FEHA) (California Government Code, Section 12900 and following) and the regulations set forth in the California Code of Regulations, Title 2, Chapter 2, commencing with Section 7286.0 and following. The plan and its participating providers may not unlawfully discriminate against any employee or applicant for employment because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender. 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 Health Industry Collaboration Effort (HICE) 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 race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender. 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.
- Mandatory provider and staff civil rights and/or cultural sensitivity training.
- Participating providers can consider implementing the following:
    - Ability to capture gender identity.

[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 phone numbers, the department's TDD line, the department's Internet address, and the plan's phone number in 12-point boldface type in the following regular type statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

The applicable Member Services Department telephone number for each line of business should also be included.

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
- State Requirement for Providing Behavioral Health Services

Application Process

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

Practitioners or organizational providers subject to credentialing or recredentialing and contracting directly with the Plan must submit a completed Plan-approved application. By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes the Plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review.
- Releases the Plan and its independent contractors, agents and employees from any liability connected with the credentialing review.
- Must submit a completed Council of Affordable Quality Healthcare (CAQH) ProView Application.
- Upon receipt of the completed application from the practitioner, receive an acknowledgment letter from the Credentialing department within seven calendar days of receipt (excluding holidays).

AB 1041 Credentialing Timelines

In accordance with AB 1041, and consistent with Health Net’s internal implementation timeline, Health Net will make a credentialing determination within 90 calendar days of receipt of a complete application, effective October 2026.

If a credentialing determination is not made within the 90-calendar-day timeframe, the practitioner or provider will be provisionally approved for up to 120 calendar days unless one or more of the following apply:

- The practitioner or provider has disciplinary actions reported by a licensing board.
- There are adverse actions or malpractice reports in the National Practitioner Data Bank (NPDB).
- The practitioner or provider has not been credentialed by Health Net within the previous five years.

Credentialing Timelines

The Plan makes a credentialing determination within 90 calendar days of receipt of a completed credentialing application, including all required third-party verifications. See California Health & Safety Code Sections 1374.198 and 1380.2 (AB 1041 (2025)).

If a credentialing determination is not made within 90 calendar days, the practitioner or provider will be provisionally approved for up to 120 calendar days unless one or more of the following apply:

- The practitioner or provider has disciplinary actions reported by a licensing board.
- There are adverse actions or malpractice reports in the National Practitioner Data Bank.
- The practitioner or provider has not been credentialed by the Plan within the previous five years.

Standards of Practitioners

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 a CAQH credentialing application and supply supporting documentation, if required. The verification time limit for a Plan-approved application is 120 days. Applications are available at the CAQH for the ProView Credentialing link.

Supporting documentation includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate 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 – $1 million/$3 million; organizational providers – $3 million/$10 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 Office of the Inspector General's sanctions list of individuals and entities if treating Medicaid and Medicare members.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.
- The Excluded Parties List System (EPLS) through the System for Award Management (SAM) Report.

- The Medi-Cal Suspended and Ineligible Provider listing.
- The Medicare Preclusion List.
- State licensing medical board for disciplinary actions/restrictions.
- Restricted Provider Database.

Limitation on Requests for Additional Information

Effective January 1, 2028, requests for additional information during the credentialing or recredentialing process are limited to information necessary to clarify or verify data submitted through the CAQH credentialing application, in accordance with AB 1041. Providers must respond to such request within 10 business days.

Credentialing Responsibility, Oversight and Delegation

The Plan may delegate 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 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, or more frequent, review as applicable.

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 behavioral healthcare provider losing delegated credentialing status must complete the Plan's initial credentialing process within six months of the transition date.

Hiring Non-Participating Providers

The following document applies only to Physicians and PPGs.

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 DEA certificate or CDS certificate, as applicable.
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Malpractice insurance coverage that meets these standards: Individual providers – $1 million/$3 million; organizational providers – $3 million/$10 million.

- Absent of any sanctions that would not allow them to see a Medicare member.

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 outlined in the Provider Participation Agreement (PPA).

Practitioner types noted as technicians or assistants to contracted practitioners are exempt from the credentialing process.

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 that meet and maintain the standards for participation requirements are retained in the network.

CAQH Mandatory Submission Requirement

Effective January 1, 2028, all credentialing and recredentialing applications for applicable commercial lines of business must be submitted exclusively through CAQH in compliance with AB 1041.

Practitioners due for recredentialing must re-attest all items on the CAQH 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 DEA certificate or 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 – $1 million/$3 million; organizational providers – $3 million/$10 million.
- Trended assessment of practitioner's member’s complaints, quality of care, and performance indicators.

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. The Plan 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 Medicare/Medicaid sanctions.
- Federal Employees Health Benefits Program debarment.
- System Award Management (SAM), inclusive of Excluded Parties List System (EPLS).
- 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.

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 PPGs to which credentialing to obtain primary source information (outlined below)* in accordance with the standards of participation, state and federal regulatory requirements, and accrediting entity standards.

The Scope of Practitioners included in the Credentialing/Recredentialing Program

- Medical physicians (MD)
- Doctor of Osteopathic Medicine (DO)
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Oral surgeons (DDS/DMD)
- Doctor of Naturopathic Medicine (ND)
- Chiropractors (DC)
- Psychologist (PSY)
- Podiatrists (DPM)
- Mid-level practitioners (non-physicians)
- Licensed Clinical Social Worker (LCSW)
- Marriage and Family Therapist (MFT)
- Marriage and Family Child Counselor (MFCC)
- Applied Behavioral Analyst (ABA) Qualified Autism Service Provider (QASP)
    - Must hold a Bachelor’s Degree (BCaBAs) or a Master’s or higher (BCBA/BCBA-D) from an accredited school per requirements of the Behavioral Analyst Certification Board.
    - Must hold a clear, unrestricted Board Certification as either a BCaBA, BCBA, or BCBA-D through the Behavioral Analyst Certification Board. In states where an ABA license exists, the Plan requires an ABA license. All BCaBAs must deliver services under a group practice.
- Mental Health Counselor (MHC)
- Acupuncturist (AC)
- Audiologists (AUD)

- Speech Pathology or Therapist (SP/ST)
- Mid-Wife (Non-Physician Medical Practitioner)
- Nurse Practitioner – Mental Health (APRN)
- Optometry (OD)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Clinical Pharmacist (CP)

Primary Source Verification

The following information is collected for each applicant. The documentation will be current and verified within 120 days of submission to the credentialing chairperson (Clean File Review) or the Credentialing Committee for review and approval:

- License
- DEA (as Applicable)
- 5-years of work history, with no gaps > 6-months (Initial Credentialing only)
- Malpractice insurance coverage
- Education/training (initial credentialing only)
    - Medical school
    - Post graduate training
    - Residency
    - Fellowship
    - Masters-level training
    - Completed and qualified training as issued by the applicable state licensing board
- Board certification
- Hospital privileges (as applicable)
- Sanctions
- Claims history (National Practitioner Data Bank)
- Performance data/member complaints/grievances (recredentialing or practitioners losing delegation only)

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 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 reverifies 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.

Practitioner's Office Standards

General practitioner office standards

- Office must be professional and secular.
- Signs identifying office must be visible.
- Office must be clean.
- Office must be free of pests.
- Office must have a separate waiting area with adequate seating.
- Practitioner must see patients within 15 minutes of the scheduled appointment time.
- Clean restrooms must be available.
- Office environment must be physically safe.
- Practitioners must have a professional and fully confidential phone line and answering machine or voicemail greeting. Practitioners must ensure their voicemail boxes are routinely cleared and able to accept incoming messages.
- Practitioner’s after-hours voicemail message must include emergency instructions advising members to contact 911 for medical emergencies.

Additional standards for practitioner home office (Behavioral Health Only):

- Office must have a separate entrance for clients/patients.
- Office must be used only for business and may not be used as part of living area.
- There must be a waiting area separate from living area.
- There must be a restroom separate from living area.
- Practitioner must have a separate phone line that is not accessible to other household residents or household staff.

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 denial, limitation, suspension, or termination of credentialing status consistent with 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.

For providers approved for participation, including those approved on a provisional basis as permitted under applicable law, the Plan will activate the provider promptly and notify the provider of activation within 10 business days, in accordance with California AB 1041.

For providers approved for participation, including those approved on a provisional basis as permitted under applicable law, Health Net will activate the provider promptly and notify the provider of activation within 10-business days, in accordance with California Assembly Bill (AB) 1041.

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's decision during an informal reconsideration is 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 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.

Organizational Providers Certification or Recertification

An organizational provider 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 organizational providers include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and ambulatory surgical centers (ASCs).

Below are the credentialing requirements for organizational providers:

- The submission of an application which affirms the completeness and truthfulness of representations made in the application.
- 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.
- Organizational providers are recertified every 36-months to ensure eligibility requirements.
- The Organizational provider is not required to submit an application for recertification.

Organizational providers that require assessments by the Plan or its delegated entities include:

- Hospitals
- Home health, hospice and home infusion providers
- Skilled Nursing Facilities (SNF)
- Free-standing and ASCs, including abortion clinics
- Dialysis/End-Stage Renal Disease (ESRD) care providers
- Hospices
- Clinical laboratories
- Office-based surgery suites
- Ambulatory psychiatric and addiction disorder facilities and clinics
- Acute care, behavioral health in hospitals, or other freestanding psychiatric hospitals or treatment facilities
- Comprehensive outpatient rehabilitation facilities
- Physical therapy and speech pathology providers
- Portable X-ray suppliers
- Radiology/imaging centers
- Advanced Diagnostic Imaging (ADI)
- Behavioral health/psychiatric disorder facilities (inpatient, residential, ambulatory, and clinics.)
- Sleep study centers
- Urgent care centers
- Federally Qualified Health Centers, Indian Health Centers and Rural Health Clinics
- Community-Based Adult Services (CBAS) centers
- Occupational therapy
- Outpatient self-management training providers
- Other providers as deemed necessary
- Intermediate Care Facility
- Telehealth provider
- CalAIM- Community Supports Provider – Vetting Only
- Enhanced Care Management

CalAIM - Community Supports Provider/In Lieu of Services Provider.**

Non-traditional providers are not certified or credentialed. They require vetting to ensure acceptance into the Plan's network. Note, if a traditional provider, hospital, ancillary, PPG or practitioner oversee the non-traditional provider, the provider is responsible to ensure they meet the needs to join the Plan's network.

- Assisted Living Facility (ALF) Transitions
- Asthma Remediation
- Day Habilitation Program
- Environmental Accessibility Adaptions (Home Modifications)
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Housing Transition Navigation Services
- Medically Tailored Meals or Medically Supportive Foods
- Personal Care and Homemaker Services

- Recuperative Care (Medical Respite)
- Respite Services
- Short-Term Post Hospitalization Housing
- Sobering Centers
- Transitional Rent

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 and must be licensed to operate in the state and comply with all applicable federal and 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 licensure; state, county, fictitious name permit or license exemption.
- Evidence of accreditation
- If not accredited, evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an 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 plan of correction and DHHS corrective action plan of the plan of correction acceptance letter.
- Overview of the facility's quality assurance/quality improvement program upon request.
- CBAS are exempt from accreditation but require a Department of the Aging - Site Survey.
- Urgent care, physical therapy, Community Support providers, Enhanced Care Management providers, and Intermediate Care Facilities are exempt from accreditation and site surveys.

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, including a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guidelines.
    - The requesting provider must be advised 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."
        - If the decision was based on medical necessity, the notification must include a reference to the clinical criteria that has not been met.
        - If the denial is related to a member who has a terminal illness, a description of alternative treatment, drug, services or supplies covered by the Plan, if any.
- 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 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 Healthcare Industry Collaboration Effort (HICE) website at www.iceforhealth.org/home.asp to view the Denial File Fax Back template located under Approved HICE 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 Health Industry Collaboration Effort (HICE) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the HICE website at www.iceforhealth.org/home.asp to locate the Approved HICE Documents for the commercial and Medi-Cal ICE UM Timeliness Standards.

The National Committee for Quality Assurance (NCQA) counts the time from the date when Health Net receives the request, regardless of whether it is during business hours. Non-urgent requests may be processed on the next business day. Refer to Notification Delays for notification timelines when expert consultation is required to made the initial decision.

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 Health Net or Availity Essentials provider portal.

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.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website for details on what functions can be accessed through each portal.

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.

- Online through one of the following provider portals:
  - Health Net: Log in, select *Eligibility* at the top of the page, select *Eligibility Check.*
  - Availity Essentials: Log in, go to the *Patient Registration* section, select *Eligibility and Benefits*.

- The interactive voice response (IVR) system (not applicable to Behavioral Health providers) for employer group HMO 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.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website for details on what functions can be accessed through each portal.

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 | Hospitals | Participating Physician Groups (PPG)

Emergency care is covered for an emergency medical condition, which is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an emergency medical condition. Active labor means labor at the time that either of the following could reasonably be expected to occur: (1) there is inadequate time to effectively transfer safely to another hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the member or unborn child.

Emergency care includes:

- Medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
- Additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.
- Air and ground ambulance and ambulance transport services provided through the 911 emergency response system.

Health Net makes final decisions about emergency care.

Refer to the following Behavioral Health definition in the glossary for more information.



- Psychiatric emergency medical condition
- Life Threatening Emergency
- Non-Life Threatening Emergency
- Urgent
- Routine
- Emergency Services and 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
- Subscriber and Member Identification Numbers
- Use of Social Security Numbers
- Late Enrollment Rules Waived

Dependent Documentation Provided to Non-Subscriber

Provider Type: Physicians | Participating Physician Groups (PPG)

AB 2130 (ch. 809, 2000) and SB 943 (ch. 755, 2001) require Health Net to provide a copy of a dependent's identification (ID) card, disclosure form, Evidence of Coverage (EOC) or Certificate of Insurance (COI), and any other information regarding the dependent's health care coverage to a non-covered parent or any person having legal custody of the dependent. The information must also be provided to the local child support agency when requested.

Subscriber and Member Identification Numbers

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

The plan develops unique identification (ID) numbers for all subscribers. The group subscriber ID number is formatted as an alphanumeric code, beginning with the letter "R" followed by eight digits. The individual Medicare subscriber ID number is formatted as an alphanumeric code, beginning with the letter "C" followed by eight digits.

With the exception of Medicare members, individual members of a subscriber's household are assigned the same subscriber ID number as the subscriber and a unique member code identifying the relationship of the member to the subscriber. Medicare members have one member 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

This section contains information regarding medical records.

Select any subject below:

- Medical Records
- Confidentiality of Medical Records
- Medical Record Documentation
- Medical Record Documentation Standards
- Medical Records Performance Measurements
- Medical Record Forms and Aids
- Advanced Directive

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 for Medi-Cal and five years for Commercial. 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 10 years for Medi-Cal and five years for Commercial, 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 10 years for Medi-Cal and five years for Commercial 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 Quality Improvement Health Equity Committee (QIHEC). The standards form the basis for the evaluation of medical records by Health Net. Medical records for primary care physicians (PCPs) may be selected for evaluation as part of the annual delegation oversight assessment.

Health Net requires participating providers to have a written policy in place that provides for the protection of confidential protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism designed to safeguard medical records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about member information to maintain confidentiality.

Provision of Medical Records

The following applies to these counties: Los Angeles, Amador, Calaveras, Inyo, Mono, Tuolumne , Sacramento, San Joaquin, Stanislaus, Tulare.

Participating physician groups (PPGs), physicians, hospitals and ancillary providers are required to provide Health Net with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net can make claims and benefit determinations for Health Net utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the 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 the 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 if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice. However, access to records and audits

that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When Health Net requests access to electronic medical records (EMR), the provider will grant the health plan access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the health plan for this access.

Written Protocols

Participating providers are required to have systems and procedures in place that provide consistent, confidential and comprehensive record-keeping practices. Written procedures must be available upon Health Net's request for:

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included
- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)
- Formal system for the availability and retrieval of medical records - Policy and procedure must allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - Policy and procedure must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with state laws and regulations (for providers who see commercial health plan patients)
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicare patients)
- Preventive care guidelines for pediatric and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates,

maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of member information

Provision of Medical Records (CalViva Health)

The following applies to these counties: Fresno, Kings, Madera.

Participating physician groups (PPGs), physicians, hospitals, and ancillary providers are required to provide Health Net and CalViva Health with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net and CalViva Health can make claims and benefit determinations for utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Provision of Medical Records (Community Health Plan of Imperial Valley)

The following applies to Imperial County.

Participating physician groups (PPGs), physicians, hospitals, and ancillary providers are required to provide Health Net and Community Health Plan of Imperial Valley (CHPIV) with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net and CHPIV can make claims and benefit determinations for utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

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.

Medical information includes immigration status and place of birth

In accordance with Senate Bill 81, medical information and protected health information (PHI) explicitly includes immigration status (past or present) and place of birth, when such information is known or collected. **These data elements must be treated with the same level of confidentiality and protection** as all other individually identifiable health information under the Confidentiality of Medical Information Act (CMIA) and HIPAA.

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.

Prohibition on disclosure for immigration enforcement

Disclosure of protected health information (PHI), including medical information such as immigration status and place of birth, for immigration enforcement purposes is strictly prohibited unless required by federal law.

Health Net and its affiliated entities must not, to the extent possible, allow access to patient information or facilities for immigration enforcement activities unless a valid judicial warrant or court order is presented.

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

Visitor access and immigration enforcement procedures

- Participating providers must have in place procedures for monitoring, documenting, and receiving visitors to ensure compliance with privacy and security standards.
- Staff must be trained to immediately notify facility management, administration or legal counsel upon receiving any request for access to the site or to a patient for immigration enforcement purposes.
- Requests for review of documents or access to nonpublic areas must be directed to designated personnel and must not be granted unless accompanied by a valid judicial warrant or court order.
- Participating providers must clearly define and designate nonpublic areas, including treatment spaces and locations where protected health information is discussed, using signage, access controls or mapping.
- Denials of access to nonpublic areas for immigration enforcement should be witnessed and documented by at least one staff member.

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.

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 advanced 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 the 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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net has various medical record documentation forms and aids for participating providers.

- Advanced 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)

Advanced Directives

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

An “Advanced 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 “Advanced Health Directive”: The right to learn about changes to the law regarding Advanced Health Directives; The right to have their Advanced Health Directive be placed in their medical record; and The right to change or cancel their Advanced Health Directive at any time.

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:

- Advanced Directives
- Member Rights and Responsibilities

Advanced Directives

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

Providers should consider discussing advanced 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 advanced 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 advanced directive.

An advanced directive is a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office. 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 advanced health care directive is legally sufficient if all the following requirements are satisfied:

- The advanced directive contains the date of its execution

- The advanced 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 advanced 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 advanced 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 advanced 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 advanced 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 advanced directive

For additional information on Advanced 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 their rights and responsibilities.
- Receive information about their Plan, the services their Plan offers the member, and the health care providers available to care for the member.
- Make recommendations regarding the Plan’s member rights and responsibilities policy.
- Receive information about all health care services available to the member, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for their care, and whether their deductible or out-of-pocket maximum has been met.
- Choose a health care provider in their Plan’s network, and change to another doctor in their Plan’s network if the member is not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a health care provider in their Plan's network, including one with a specialist.
- Have an appointment with a health care provider outside of their Plan’s network when their Plan cannot provide timely access to care with an in-network health care provider.
- Certain accommodations for their disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a health care provider’s office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if the member needs it.
    - Taking their service animal into exam rooms with them.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-inclusive health care, which includes all medically necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by their preferred name and pronoun
- Receive from their health care provider, upon request, all appropriate information regarding their health problem or medical condition, treatment plan, and any proposed appropriate or medically necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so the member can make an informed decision before the member receives treatment.

- Participate with their health care providers in making decisions about their health care, including giving informed consent when the member receives treatment. To the extent permitted by law, the member also has the right to refuse treatment.
- A discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Receive health care coverage even if the member has a pre-existing condition.
- Receive medically necessary treatment of a mental health or substance use disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a health care provider.
- Request from their Plan a second opinion by an appropriately qualified health care provider.
- Expect their Plan to keep the member's personal health information private by following its privacy policies, and state and federal laws.
- Ask most health care providers for information regarding who has received their personal health information.
- Ask their Plan or their doctor to contact them only in certain ways or at certain locations.
- Have their medical information related to sensitive services protected.
- Get a copy of their records and add their own notes. The member may ask their doctor or health plan to change information about them in their medical records if it is not correct or complete. The member's doctor or health plan may deny their request. If this happens, the member may add a statement to their file explaining the information.
- Have an interpreter who speaks their language at all points of contact when the member receives health care services.
- Have an interpreter provided at no cost to the member.
- Receive written materials in their preferred language where required by law.
- Have health information provided in a usable format if the member is blind, deaf, or has low vision.
- Request continuity of care if their health care provider or medical group leaves the member's Plan or the member is a new Plan member.
- Have an advanced health care directive.
- Be fully informed about their Plan's grievances procedure and understand how to use it without fear of interruption to their health care.
- File a complaint, grievance, or appeal in their preferred language about:
    - Their Plan or health care provider.
    - Any care the member receives, or access to care the member seeks.
    - Any covered service or benefit decision that their Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of trans-inclusive health care, including medically necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting their language needs.
- Know why their Plan denies a service or treatment.
- Contact the Department of Managed Health Care if the member is having difficulty accessing health care services or has questions about their Plan.
- To ask for an independent medical review if their Plan denied, modified, or delayed a health care service.

As a Plan member, members have the responsibility to:

- Treat all health care providers, health care provider staff, and Plan staff with respect and dignity.
- Share the information needed with their Plan and health care providers, to the extent possible, to help get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with their health care providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call their health care provider if the member may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to their Plan or health care provider.
- Notify their Plan if they have any changes to their name, address, or family members covered under their Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify their Plan as soon as reasonably possible if the member is billed inappropriately.

Prescription Drug Program

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

This section contains general member benefit information on the prescription drug program.

Select any subject below:

- Compounded Medications
- Coverage Explanation
- Diabetic Supplies
- Exclusions and Limitations
- Generic Medications
- Off-Label Medication Use
- Participating Pharmacy
- Physician Self-Treatment
- Prescription Mail-Order Program
- Prior Authorization Process
- Quantity of Medication to Be Prescribed
- Recommended Drug List

Exclusions and Limitations

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

The following list of exclusions and limitations (benefits vary by plan) applies to the Health Net prescription drug program:

- Medications prescribed by a non-participating physician are not covered except when the physician's services have been authorized because of a medical emergency, illness or injury, or the physician is the authorized referring physician.
- Allergy serum.
- Appetite suppressants or medications for body weight reduction, unless medically necessary for morbid obesity, require prior authorization.
- Blood.
- Compounded medications - Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using Food and Drug Administration (FDA)-approved medications, are covered at the Level III copayment. Coverage for compounded medications is subject to prior authorization by the plan and medical necessity. Compounded medications are not covered if there is a similar proprietary product available.
- Devices other than diaphragms.
- Dietary or nutritional supplements - Medications used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to medications that are listed in the Recommended Drug List (RDL). Phenylketonuria (PKU) is covered under the medical benefit.
- 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 Find a Provider.

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:

- Behavioral Health General Policies
- 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
- Prior Authorization Requirements

Behavioral Health General Policies

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

This section describes authorization for higher levels of care (e.g., inpatient psychiatric, residential treatment, partial hospitalization, intensive outpatient, inpatient detoxification, substance abuse rehabilitation) using the Medical Necessity Guidelines for admissions outlined in this manual.

Health Net is committed to providing timely high-quality care, delivered by the right provider in the least restrictive treatment setting. Health Net achieves this goal through prior authorization requirements for certain treatment services.

Prior authorization provides benefits to the member by ensuring that treatments are used appropriately and serves a safeguard against treatments that may be subject to misuse or abuse. Members may also realize reduced costs by first considering alternative treatments that are as safe and effective as those proposed.

Additional value is created by considering the member within their environment and bringing those issues together to create a comprehensive treatment plan, as well as coordination of the delivery of those services. This process allows the Utilization Review Clinicians to answer the question, “where and how can this member be treated safely and most effectively in an environment that will promote optimal functioning”.

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 submit prior authorization requests online:

Availity Essentials	Health Net
1. Log in, then go to the appropriate section for prior authorizations, typically found under *Patient Registration* or *Authorizations*. 2. Follow the prompts to enter the required member and service information, then click *Submit* to complete the prior authorization request.	1. Log in, then select the applicable line of business from the drop-down menu > *Go.* 2. Once you have checked the member's eligibility, select the member's blue hyperlinked name > *Authorizations.* 3. Complete the required information to request prior authorization, including submitting the appropriate Smart Sheet for which a link can be found under the Authorizations tab. Access prior authorization tools and resources on the Health Net website . You can find information on: • Validation tools. • Prior authorization requirements lists. • Inpatient and outpatient forms.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website (HMO/PPO/Health Net Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley, Wellcare By Health Net) for details on what functions can be accessed through each portal.

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 Health Net. Health Net also requires participating hospitals and ancillary providers to request prior authorization.

Health Net members and providers may contact Health Net – Prior Authorization for prior authorization.

The following steps outline the process when a member or provider contacts Health Net – Prior Authorization.

- A Health Net representative 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.
- The Health Net representative will submit the Prior Authorization request to the Health Net Medical Management Department for review and processing.
- Health Net Medical Management will review the request with all the pertinent information and issue a determination.
- Notification of approvals and denials will be made to the requesting provider within 24 hours of the decision by either fax, phone or electronic notice.
- The Health Net Medical Management Department will issue a written notice of the determination to the member and provider.

- If the request for authorization is denied, 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.

Behavioral health authorization process

Health Net has licensed clinical staff available 24 hours a day, seven days a week to provide prior authorization for acute inpatient care. Patient care is pre-certified when a treating practitioner or facility submits initial clinical information and requests authorization prior to admission.

If authorization cannot be obtained before admission, Health Net requires facilities to submit authorization requests within 24 hours of admission to any higher level of care treatment service. These services include mental health and substance use disorder inpatient care, acute detox, residential treatment, partial hospitalization, and intensive outpatient programs.

Except in cases of extenuating circumstances, failure to request authorization within 24 hours of admission may result in denial of authorization.

Prior authorization procedures

1. Facility providers must contact Health Net to request prior authorization. The preferred method for submitting prior authorization requests is online through the Availity Essentials secure provider portal (for Ambetter HMO/PPO, Employer Group HMO/POS, and Wellcare by Health Net members). If unable to submit online, refer Behavioral Health Contact information page for Prior Authorization contacts.
2. Health Net Utilization Review Clinicians conduct prior authorization reviews according to the following guidelines:

- **The Utilization Review Clinician assesses the patient's clinical presentation** according to medical necessity guidelines for the specific care setting, plan type, and intensity of service being proposed. This assessment includes the patient's presenting problem, mental status, current diagnosis, previous psychiatric or substance abuse treatment, and relevant psychosocial factors.
- **If medical necessity criteria for the requested level of care are met**, the facility provider is given both verbal and written authorization. If the prior authorization occurs during non-regular business hours, the authorization is issued as "pending eligibility verification." The facility provider is instructed to admit the patient to the proposed care setting and contact Health Net during regular business hours to verify eligibility.
- **If medical necessity criteria are not met**, the facility provider is notified verbally, and an alternative care plan or setting is discussed. If an agreement is reached, written confirmation of the alternative plan is provided. If no agreement can be reached, the Utilization Review Clinician explains the secondary review process and refers the case to a Health Net medical director for further evaluation.

Initial Authorization

1. Facility providers initiate requests for authorization through the Availity Essentials secure provider portal, or if unable to submit online via fax or phone, for all higher levels of care.
2. A Health Net Utilization Review Clinician reviews requests for medical necessity and applies medical necessity criteria.
3. If the case does not appear to meet medical necessity criteria for the level of care requested, the Utilization Review Clinician refers the case to a Health Net medical director for review.
4. If the medical director denies authorization, refer to the non-certification procedure.
5. Once authorization is established, the Utilization Review Clinician notifies the requesting facility of the decision and sets a date for concurrent review.
6. The Utilization Review Clinician generates an authorization verification letter to be mailed to the provider and patient.

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.

Effective November 12, 2026 - Applicable to Medicare Advantage only.

For inpatient (IP) and post-acute care (PAC) authorization determinations, Peer-to-peer discussions support physician-to-physician clinical dialogue and are educational in nature. They do not constitute a request for reconsideration. Providers who disagree with an adverse determination must submit a reconsideration request through the Medicare appeals process.

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
- Elect Open Access Tier 2 (PPO Limited Benefit) Plan

Elect Open Access Tier 1 (HMO) Benefit Level

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

The Elect Open Access Tier 1 (HMO) plan offers comprehensive care at a lower cost to members who use Health Net's participating providers for care. Elect Open Access Tier 1 is similar to a traditional HMO plan. The member chooses a primary care physician (PCP) who is responsible for providing or coordinating the member's care. If the member requires services outside the PCP's scope of practice, the PCP refers the member to a specialist or other ancillary provider.

Elect Open Access Tier 2 (PPO Limited Benefit) Plan

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

Under the Elect Open Access Tier 2 (PPO limited benefit) plan, the member can self-refer to obtain consultation services from any provider in the Health Net PPO network without a referral. Services are limited to physician office visits and care that can be performed in the physician's office (for example, laboratory and radiology services). All other covered services, including hospitalization, maternity care, outpatient surgery, and home health care, must be obtained through the member's HMO level of benefits under Elect Open Access Tier 1 (HMO). Members receiving care from PPO providers incur higher out-of-pocket expenses than they would at the Elect Open Access Tier 1 level.

Elect Two Tier Plan

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

This section contains general information about the Elect Two-Tier health plan.

Select any subject below:

- Elect Tier 1 (HMO) Benefit Level
- Elect Tier 2 (PPO In-Network) Benefit Level

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.

health net

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
- Participating Physician Group (PPG) Performance Management

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.

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.

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.

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:

National Committee for Quality Assurance Health Plan Accreditation Standards and Quality Assessments and Improvements. Each Provider agrees to: (i) cooperate with Quality Management and Improvement (“QI”) activities; (ii) maintain the confidentiality of Covered Persons’ information and records pursuant to the Agreement; and (iii) allow the Company to use Provider’s performance data. Moreover, each Provider shall participate in, cooperate with, and its performance shall be measured in accordance with applicable quality measures and criteria, including but not limited to, Company Policies, Office of the Patient Advocate, STARS and External Accountability Set.

Facility and Physician Additions, Changes and Deletions

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

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

Select any subject below:

- Overview
- Facility and Satellites
- Hospitals Adequate Supplies and Staffing
- PPG and Hospital Termination
- Provider Online Demographic Data Verification
- Provider Outreach Requirements
- Mandatory Notification Requirements for PPG Downstream Hospital Terminations

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.

Hospitals Adequate Supplies and Staffing

Hospitals

Hospitals must maintain adequate supplies and staffing levels to ensure that they are fully equipped to provide comprehensive care to all patients who need medical attention.

If a hospital's capacity to provide complete care is compromised, including any facility issues or labor actions that may affect available resources, they are required to promptly notify their Provider Engagement Network Specialist (PENS).

This notification is essential for Health Net to be able to act and work to minimize any potential impact on patient care. Prioritizing these actions helps hospitals meet patient needs and maintain health care standards.

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.

Including but not limited to:

- Partial terminations, including the loss of a specific service
- Constructive terminations
- Novations
- Non-renewals
- Contract assignments

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 Find a Provider. 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.

If a provider who is not accepting new patients is contacted by a member or potential member seeking to become a new patient, the practitioner must direct the member or potential member to both Health Net for additional assistance in finding a provider, and, if applicable, to the Department of Managed Health Care (DMHC) to report any inaccuracies with Health Net's directory.

Providers directly contracting with Health Net must notify Health Net of changes to their demographic information 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 providers biannually, including physicians and other health professionals such as physical therapists (PTs), occupational therapists (OTs) and podiatrists, and annually contact participating physician groups (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. This must include 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 provider 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

The “accepting new patients” status means being open to new patients and patients can schedule an initial appointment without being placed solely on a waitlist. 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, 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 healthcare service facility or due to his or her provision of healthcare 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.

Mandatory Notification Requirements for PPG Downstream Hospital Terminations

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

Participating physician groups (PPGs) must notify the Health Net when a contracted hospital terminates from their network for any reason, including but not limited to:

- Partial terminations, including the loss of a specific service
- Constructive terminations
- Novations
- Non-renewals
- Contract assignments

Timely notification allows Health Net to:

- Maintain accurate provider directories.
- Meet regulatory reporting and member notification requirements.
- Ensure appropriate continuity of care protections for impacted members.

Block transfer filings

Hospital network terminations that may impact member access or continuity of care require Health Net to submit a Block Transfer Filing to the Department of Managed Health Care (DMHC).

Note: A terminating hospital may not be removed from the network until approval of the Block Transfer Filing has been obtained from the DMHC.

Notification timing and submission

PPGs must notify their assigned Provider Engagement network specialist as soon as a hospital termination is known or anticipated, including planned non-renewals or early terminations, at least 180 days in advance. This must include termination details and effective dates.

Required information

PPGs must submit termination-related information using a standardized form at least 120 business days prior to the termination. The form will be provided by the PPG's assigned Provider Engagement network specialist. Required information includes, but is not limited to:

- Hospital termination notice and effective date.
- Hospital extension notice (if applicable).
- Enrollee notification materials and distribution timing.
- COC approach and impacted members.
- Scope and impact of the termination, including affected lines of business.

Noncompliance

Failure to provide timely and complete notification may result in corrective action and may also affect the PPG's delegation status.

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
- Claims Payment Requirements

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 physicians, other 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 physicians and other 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 physicians and other 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, physician/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 Evidence of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care 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 physician's or other provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and an 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.

Behavioral Health Facility Access and Availability

Per their contract with Health Net, network facilities should be available and accessible to members during reasonable hours of operation. Emergency care, where applicable, should also be available and accessible 24 hours a day. Facility information regarding hours of operation is collected every two years via Health Net's facility application for recredentialing. Facilities must notify Health Net of any changes in their hours of operation or lapses in accessibility or availability as needed.

After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating physicians and other 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 phone 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 phone. For PPGs or physicians who use an automated answering system, this template can be used as a script to advise members on how to access care. Health Net's after-hours scripts provide easy to use messaging examples on how to direct members to emergency care services and who to talk to when they need urgent medical advice.

Health Net makes the script in the following threshold languages:

- English (PDF)
- Spanish (PDF)
- Chinese (traditional) (PDF)
- Chinese (simplified) (PDF)

After-hours scripts are available in additional languages upon request. Contact the Provider Network Management, Access and Availability Team for more information.

Answering Services

Physicians and other 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 physician or other provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide phone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain 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 phone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed physician or other 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.
- Question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return phone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered 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 physicians and other 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 phone. This program is a service offered in conjunction with the PCP and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all

PCPs must provide 24-hour phone service for urgent/emergent instructions, medical condition assessment and advice. The Health Net Member Services Department coordinates member access to the service, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide instruction on home and care techniques and general health information.

Health Net ensures that phone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. Health Net provides triage or screening services through a contracted medical/nurse advice line. Health Net members can access these services by contacting the Nurse Advice Line phone number on the back of their ID cards.

Facility Access for the Disabled

Health Net and its participating physicians and other providers do not discriminate against members who have physical disabilities. Participating physicians and other 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.

Physicians and other 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. Physicians and other 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 members may seek care through participating physicians and other providers or out-of-network physicians/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 physician, other 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 physician or other 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 physician or other provider has determined to extend the appointment wait time, the physician or other 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 with another physician/provider or urgent care facility.

Provider Phone Assessment

Phone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs and nurse practitioners (NPs)) and only in accordance with established standards of practice.

Telehealth

Telehealth services are subject to the requirements and conditions of the member benefit plan and the contract entered into between Health Net and its participating physicians and other providers. Prior to the delivery of health care via telehealth, the participating physician or other 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 physicians and other 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 physicians and other 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 physician or other 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 physician or other 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 physician or other provider the minor is mature enough to participate intelligently in the outpatient or residential shelter services – CFC § 6924.
- Skeletal X-ray - a health care physician or other 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 §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).

Minor's consent for services – Mental health services

Members aged 12 or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the minor, in the opinion of the attending professional, is mature enough to participate intelligently in the outpatient services or residential shelter services.

A professional offering residential shelter services, whether as an individual or as a representative of an entity, shall make their best efforts to notify the parent or guardian of the provision of services.

Mental health treatment or counseling of a minor must include involvement of the minor's parent or guardian unless the professional treating or counseling the minor, after consulting with the minor, determines that such involvement would be inappropriate. The professional must document in the client record whether and when they attempted to contact the minor's parent or guardian, and whether the attempt was successful or unsuccessful, or the reason why, in their professional opinion, it would be inappropriate to contact the parent or guardian.

The minor's parents or guardian are not liable for payment for mental health treatment or counseling services unless they participate in the treatment or counseling, and then only for services rendered with their participation. The minor's parents or guardian are not liable for payment for any residential shelter services provided under this section unless they consented to the provision of those services.

This section does not authorize a minor to receive convulsive therapy or psychosurgery, as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

Prior Authorization Processes

Health Net requires prior authorizations to be processed and completed in a manner that assures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered. For example, expedited utilization management review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [28 CCR 1300.67.2.2(c)(5)(B)], more commonly known as urgent pre-service requests, must be conducted concurrently, or the prior authorization turnaround timeline must be shortened to allow sufficient time to communicate the outcome to the member and/or the referring physician or other provider and ensure an appointment is offered to the member within 96 hours of the request. Refer to Prior Authorization for more information.

Quality Assurance

Health Net has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, Health Net monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, Health Net reviews and evaluates the information available to Health Net regarding accessibility, availability and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service phone

access to measure performance, confirm compliance and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

Health Net's participating providers (including delegated providers) are contractually required to participate in all timely access or accreditation surveys and studies administered by or on behalf of regulatory agencies such as DHCS, DMHC and Centers for the Medicare & Medicaid Services (CMS).

At least on a quarterly basis, Health Net will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to a member that are related to access. Health Net 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 for monitoring 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 conducts provider surveys to measure and evaluate member access. Listed below are Health Net's performance goals for access-related, time-elapsed provider criteria:

Health Net 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%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
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 phone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Net Commercial (HMO, POS, PPO) 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 MEASURE	STANDARD	PERFORMANCE GOAL
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Non-urgent appointment with non-physician behavioral health care provider for routine care[3]	Appointment within 10 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%
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 business appointment access policy and procedure (CA.NM.05), is not met.

Health Net uses the following criteria to identify 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 phone services, as necessary.

CAP Minimum Requirements

- Each PPG is required to send in a written improvement plan to include what interventions will be implemented for each deficiency to improve access availability. The improvement plan must include:
    - Date of implementation of the improvement plan.
    - Department/person responsible for the implementation and follow-up of the improvement plan.
    - Anticipated date that the improvement plan is expected to produce outcomes that result in correcting the deficiency.
- The PPG is to return the improvement plan 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 Provider 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 improvement plan within the prescribed time frame, the Provider Network Management 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 Provider Network Management 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 PPO and Ambetter PPO Geo-Access Standards*

Provider Type	DMHC
PCP	15 miles/30 minutes*
Hospital	15 miles/30 minutes*
Ancillary	reasonable distance from PCP

*Time or distance standards are from the members' residence.

There are no DMHC regulatory standards for Ancillary, other than reasonable distance. Health Net has set the following standards for Ancillary to be reviewed at 90 percent within 15 miles or 30 minutes from the PCP locations.

DMHC County Size Categories by Population

COUNTY	DESIGNAION	COUNTY	DESIGNATION
Alameda	Large Metro	Orange	Large Metro
Alpine	CEAC	Placer	Metro
Amador	Micro	Plumas	CEAC
Butte	Metro	Riverside	Metro
Calaveras	Rural	Sacramento	Large Metro
Colusa	Rural	San Benito	Micro
Contra Costa	Large Metro	San Bernardino	Metro
Del Norte	Rural	San Diego	Metro
El Dorado	Metro	San Francisco	Large Metro
Fresno	Metro	San Joaquin	Metro
Glenn	Rural	San Luis Obispo	Metro
Humboldt	Micro	San Mateo	Large Metro
Imperial	Micro	Santa Barbara	Metro
Inyo	CEAC	Santa Clara	Large Metro
Kern	Metro	Santa Cruz	Metro
Kings	Metro	Shasta	Micro

COUNTY	DESIGNAION	COUNTY	DESIGNATION
Lake	Micro	Sierra	CEAC
Lassen	CEAC	Siskiyou	CEAC
Los Angeles	Large Metro	Solano	Metro
Madera	Micro	Sonoma	Metro
Marin	Metro	Stanislaus	Metro
Mariposa	Rural	Sutter	Metro
Mendocino	Micro	Tehama	Micro
Merced	Metro	Trinity	CEAC
Modoc	CEAC	Tulare	Metro
Mono	CEAC	Tuolumne	Micro
Monterey	Metro	Ventura	Metro
Napa	Metro	Yolo	Metro
Nevada	Metro	Yuba	Metro

Specialist 90% Threshold - Standard in Miles

County Designation	Specialist Group 1	Specialist Group 2
Large Metro	15^	15^^
Metro	20*	25*
Micro	55	65

County Designation	Specialist Group 1	Specialist Group 2
Rural	55	65
CEAC	100	125

Specialist Group 1: cardiovascular disease, dermatology, gastroenterology, neurology, obstetrics/gynecology, oncology, ophthalmology, podiatry, pulmonology, surgery-general, and surgery-orthopedic.

Specialist Group 2: allergy/immunology, endocrinology, hematology, nephrology, otolaryngology, pain medicine, physical medicine and rehabilitation, radiation oncology, rheumatology, and urology.

DMHC has options for Alternative Low Density Zip Standard – when applicable:

- Large Metro County – ^20 and ^^35 miles
- Metro County – *35 and **45 miles

Mental Health 90% Threshold - Standard in Miles

County Designation	Psychiatrist	MHP	MHF
Large Metro	15*	15	15^
Metro	20*	15~	45^^
Micro	55	35	90
Rural	55	35	90
CEAC	100	65	120

Psychiatrist means a physician reported as one of the following specialist physician types: psychiatry, child and adolescent psychiatry, consultation-liaison psychiatry, geriatric psychiatry or addiction psychiatry.

MHP (Mental Health Professionals) means a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, or Psychologist.

MHF (Mental Health Facility) means a facility identified as one of the following categories: acute psychiatric hospital, psychiatric health facility, chemical dependency recovery hospital, intensive outpatient, partial hospitalization, residential treatment, residential detoxification, and/or alcohol or other drug facility (outpatient). Also includes those facilities categorized as a general acute care hospital, where such hospital maintains an inpatient psychiatric unit.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- * for Large Metro Psychiatry – 20 miles
- ** for Metro Psychiatry – 35 miles
- ~ for Metro MHPs- 20 miles
- ^ for Large Metro MHFs - 30 miles
- ^^ for Metro MHFs - 75 miles

Physician/Practitioner to Member Ratios

CA DMHC: COMMERCIAL/HEALTH BENEFIT EXCHANGE:	
PCP	PHYSICIAN
1 FTE PCP/ 2,000 members	1 FTE physician/ 1,200 members

Open Practice Ratios

Percent of open PCP practices accepting new patients	DMHC standard	60% of PCPs in the network are accepting new patients or at least 75% of PCP locations in the network are a PCP location accepting new patients
Percent of open specialist practices accepting referrals	Internal standard	85%

Additional Ratios

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
Full Time Equivalent (FTE) PCP ratio for each type of PCP to member: • Family • General Practice • Internal Medicine • Pediatrics	100% of PCPs	1 : 2,500
• High-volume SCP (Obstetrics/Gynecology) • High impact SCP (Hematology/Oncology)	100% of SCPs	• 1 : 3,000 • 1 : 8,000
Behavior Health	100%	• 1 : 5,000

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
• MD's/DO (psychiatrists) • Psychologist • Masters Level practitioner		• 1 : 2,300 • 1 : 1,150
Autism • Qualified Autism Service Provider (BCBA) • Qualified Autism Service Professionals (BCaBA) or Paraprofessionals	100%	• 1 : 5,000 • 1 : 5,000

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 NCQA and the 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. PPGs are also responsible for monitoring data regarding their adherence to the following performance goals. Listed below are the appointment access provider criteria and performance goals for:

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)

According to utilization management (UM) standards, all UM-delegated 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 time frame 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.
- For cases where expert consultation is required to make initial decision

Type of request	Notification
Non-urgent pre-service	If a consultation is required by an expert reviewer, upon the expiration of the regulatory time frame (five business days for HMO and PPO and seven calendar days for Medicare) or as soon as Health Net becomes aware that regulatory time frame will not be met, whichever occurs first, practitioner and member will be notified of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 45 calendar days from the date of the delay notice to the practitioner and member).
Post-service	If a consultation is required by an expert reviewer, upon the expiration of the 30 calendar days or as soon as Health Net becomes aware that we will not meet the 30 calendar day time frame, whichever occurs first, practitioner and member will be notified of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 15 calendar days from the date of the delay notice to the practitioner and member).

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.



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

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

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

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

The National Committee for Quality Assurance (NCQA) counts the time from the date when Health Net receives the request, regardless of whether it is during business hours. Non-urgent requests may be processed on the next business day.

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 Plan

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

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.

Claims Payment Requirements

Provider Type: Participating Physician Groups (PPG) | Hospitals

Timely processing of claims is monitored via the participating physician group's (PPG's) and capitated hospital's self-reported monthly claims timeliness reports. Accuracy and timely processing of claims is verified by routine and targeted audits conducted by the Delegation Oversight staff.

Claims Payment

Claims received on or after January 1, 2026 must reimbursed fully or partially within 30 calendar days of receipt. If a claim is incomplete, the physician or other provider must be notified as soon as possible, and no later than 30 calendar days after receiving the claim.

Interest and Penalty Payments for Late Claims

For claims received prior to January 1, 202, PPGs and capitated hospitals are required to:

- Process 95 percent of commercial HMO claims within 45 business days of receipt.
- Pay 15 percent interest or $15 per year, whichever is greater, on late paid claims for emergency services rendered in the United States.

- Pay 15 percent interest on late paid claims and include an additional penalty fee of $10 if the interest is not included with the original claims payment.
- Pay 15 percent interest on late paid claims for non-emergency services rendered in the United States.
- Resolve 95 percent of provider disputes within 45 business days (if a provider dispute is in favor of the provider the check must be mailed within five days of the resolution letter, including interest if applicable).

For claims received after January 1, 2026,

- Process 95 percent of commercial HMO claims within 30 calendar days of receipt.
- Late paid claims must include interest at the rate of 15% per annum beginning with the first calendar day after the 30-calendar day period.
- Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.
- Resolve 95 percent of provider disputes within 45 business days (if a provider dispute is in favor of the provider the check must be mailed within five days of the resolution letter, including interest if applicable).

Member Notices About Incomplete Claims

PPGs and capitated hospitals must notify the member and provider in writing within 30 calendar days from receipt of the claim of an incomplete claim. Notices must specify:

- Date of denial notice.
- Member name.
- Provider name.
- Specific service.
- Date of service.
- Denied amount.
- Member responsibility amount.
- Reason for the denial - Claim denials for members must include a claim denial message.
- Provider and member appeals process and information, including plan name, address and telephone number for appeals.

Participating Physician Group (PPG) Performance Management

As the health care industry in California continues to demand increased performance and value, Health Net has improved our delegation program tools to include an enhanced PPG Performance Scorecard to evaluate PPGs in seven performance areas (PDF). Delegated PPGs are reviewed for performance measures including grievances, contractual financial requirements, delegated medical management, service and quality (see Provider Oversight). The PPG scorecard brings these together in a 360-degree view of performance through an executive dashboard format, with the goal of helping ensure that delegated PPGs are meeting or exceeding

standards. The resulting performance management process is governed by the Health Net Delegation Oversight Committee.

The PPG Performance Scorecard is used to:

- Ensure transparency in performance.
- Jointly identify opportunities to improve performance and commit to developing performance improvement plans that are regularly reviewed at joint operation meetings (JOMs) and regular meetings.
- Ensure performance exceeds minimum performance standards.
- Serve as a catalyst for corrective action and improvement plans.
- Align performance to performance standards, penalties and rewards outlined in PPG contracts.

Dissemination of scorecard results

PPGs will receive individualized scorecard results electronically on a quarterly basis via JOMs. Results, opportunities and actions are reviewed in JOMs and workgroups for PPGs with minimum membership thresholds.

Performance scoring

PPG performance is measured in seven key performance areas (PDF) including quality, delegation oversight utilization management (UM), delegation oversight claims, risk adjustment, financial solvency, network and encounters. Multiple measures are compiled and calculated by performance area. Findings are weighted by membership to form the performance score, defined through the following scale:

- 80% or greater: Performing – meeting/exceeding performance targets.
- 50-79%: Monitoring – inconsistently meeting performance targets.
- Less than 50%: Below standard – consistently below performance targets.

Sample Scorecard and Performance Improvement Resources

Sample Scorecard (PDF)

The PPG Performance Scorecard highlights performance improvement opportunities across seven domains. To learn more about how PPGs can improve their performance scores, explore the following helpful resources:

Quality Improvement and HEDIS Information

- HEDIS Measures & Billing Codes
- Provider Quality Improvement Tools

CAHPS Provider Resources

- Improve CAHPS® Results and Patient Experience – Health Net (PDF)

- Improve CAHPS® Results and Patient Experience – CalViva Health (PDF)

Provider Appointment Availability Survey (PAAS):

- Access to Care and Availability Standards – Medi-Cal
- Access to Care and Availability Standards – Commercial
- Access to Care and Availability Standards – Medicare
- Timely Access to Care Training

Encounter Improvement: Integrated Healthcare Association Encounter Data Resource Hub

Performance Management

Continued low performance may result in a corrective action plan (CAP), with expectation of improvement within a specified time-period. If performance does not improve as expected and/or as agreed, an escalation process may be activated. If necessary, formal action may be taken, which may include, but is not limited to, the following:

- Request for formal corrective action.
- A reduction in capitation.
- A freeze on enrollment.
- Revocation of delegation.
- Contract termination.

All actions taken are subject to the terms of the PPG contract.

Webinar and Training

2023 PPG Performance Scorecard Training (PDF) – A self-guided, on demand training that:

- Explains why the PPG Scorecard is being rolled out, and how it will benefit PPGs.
- Shows how the PPG Scorecard will look, how it will be distributed, and how it will be used in addition to existing performance reporting.
- Describes the seven PPG Scorecard Performance Measure areas: what's being measured, how scores are determined, and how PPGs can use this information to make focused improvements.

Quality Improvement

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

This section contains general information on Health Net's quality improvement (QI) programs, procedures and policies.

Select any subject below:

- Disease Management Programs
- Health Education Program
- Health Management Programs
- Language Assistance Program and Cultural Competency
- Quality Improvement Program

Disease Management Programs

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

This section contains general information on Health Net's disease management programs.

Select any subject below:

- Health and Wellness Program Disclaimer
- Health Net’s Health and Wellness Program

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

Nurse Advice Line

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

Wellness Programs

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

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

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

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

Disease Management Program

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

- Slow the progression of the disease and the development of complications through proven program interventions.
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines and care plans.
- Manage medications and enhance symptom control.
- Educate members regarding recommended preventive screenings and tests in accordance with national clinical guidelines.

- Reduce emergency room visits, hospitalization and medication errors, and prevent future occurrences.

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

Care Management

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

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

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

Health 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
- Health Net's Health and Wellness Program

Behavioral Health Services

Provider Type: Participating Physician Groups (PPG)

Health Net has quality initiatives to improve members' physical and mental health outcomes. Health Net focuses on various psychotropic medications, including antidepressant medication management. For example, eligible members with gaps in their antidepressant medication refills, and who are diagnosed with depression, receive automated or live outreach conducted by clinical pharmacists to remind them to continue taking their medications, refill their prescriptions and report any medication problems or concerns to their providers.

Most Health Net members appropriately seek depression treatment from their primary care physicians (PCPs), which is why Health Net provides physicians and participating physician groups (PPGs) with tools, such as Provider Tip Sheets, to support the management and coordination of care for members diagnosed with behavioral health conditions.

In an effort to increase awareness of the importance of identification and management of behavioral health conditions, among both providers and members, Health Net has been developing and posting:

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 or member companions 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's cultural competency trainings offer evidence-based practices in providing responsive, accessible care across culturally diverse populations (i.e., older adults, persons with disabilities, children with special health care needs, LGBTQIA+ communities, refugees and migrants, people experiencing homelessness (unhoused), justice involved populations). Health Net participating providers must comply with Health Net's LAP as defined in this section.

Compliance Requirements

Health Net participating providers, including providers and PPGs delegated for case management and utilization management (UM), 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 an editable version of the document within 48 hours of Health Net's request. Translation is only available in threshold languages. Alternative formats are required in all languages.
- Tagline (also known as the Notice of Availability) 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 (Khmer) (PDF)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
			Non-discrimination Notice Medi-Cal (Chinese - Traditional) (PDF)
			Non-discrimination Notice Medi-Cal (Chinese - Simplified) (PDF)
			Non-discrimination Notice Medi-Cal (Farsi) (PDF)
			Non-discrimination Notice Medi-Cal (Hmong) (PDF)
			Non-discrimination Notice Medi-Cal (Korean) (PDF)
			Non-discrimination Notice Medi-Cal (Russian) (PDF)
			Non-discrimination Notice Medi-Cal (Spanish) (PDF)
			Non-discrimination Notice Medi-Cal Tagalog) (PDF)
			Non-discrimination Notice Medi-Cal (Vietnamese) (PDF)

- Member complaint/grievance forms - Provide translated member grievance forms (provided under the Forms section of the provider library) to members upon request.
- 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 pre-scheduling through Member Services. 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, and closed captioning interpretation services are available when requested a minimum of 5-10 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 for providing translated care plans in threshold languages to members with LEP and/or their companions/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.

- 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 (HICE): Provider Tools to Care for Diverse Populations – Health Net (PDF), Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations – Community Health Plan of Imperial Valley (PDF) or Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations – CalViva Health (PDF).

Cultural Competency Training

All Health Net participating providers must take cultural competency training. Training is required upon hire and every two years afterward. 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 training within the last 24 months. Failure to complete training will result in the removal of cultural training indicator on the provider directory. PPG and delegated provider audits may result in Corrective Action Plans.

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 provides evidence-based trainings to support culturally responsive quality care for our diverse California populations, as well as our transgender and gender diverse members. Health Net encourages providers to consider evidence-based cultural competency courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Hospital Requirements

Health Net's participating hospitals are subject to requirements to provide language interpreter services for their patients pursuant to federal and state law. Health Net expects its participating hospitals to fully meet these obligations, notwithstanding Health Net's separate obligations to meet all requirements under the Health Care Language Assistance Regulations to provide language interpreter services for its members at all points of contact.

Interpreter Services Requirements

Section 1557 of the Affordable Care Act (published as 45 CFR 92) provides guidance on interpreter services, including the use of bilingual staff that act as interpreters. The guidance is summarized below.

- Provide services to individuals with LEP and individuals with a hearing incapacity that are as effective as those provided to members without LEP.
- Providers may not request or require an individual with LEP to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not rely on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the

accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances.
- Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
- Health Net members have the right to file a grievance with Health Net if their language needs are not met. Members can also file a discrimination complaint with the Office of Civil Rights if their language needs are not met.

Health Net has processes in place to ensure that members with LEP can obtain Health Net's assistance in arranging for the provision of timely interpreter services to the extent its participating hospitals are not required under state and federal law to provide a particular Health Care Language Assistance Regulations-required interpreter service.

Health Net monitors its participating hospitals for deficiencies in interpreter services and takes appropriate corrective action to address these deficiencies in the delivery of interpreter services to Health Net members.

Providers who would like to schedule trainings on topics such as cross-cultural communication, health literacy or accessing interpreter services should contact Health Net's Health Equity Department.

For additional information, refer to Health Net's Interpreter Services or the Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF), Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF) CalViva Health or Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF) Community Health Plan of Imperial Valley.

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 and Health Equity Transformation 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); and Community Based Adult Services (CBAS), which meet 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 and 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.

Behavioral health level of care criteria and clinical position papers

Behavioral Health Medical Directors consider a number of resources in this process, including our own research on the effectiveness of elements of the guidelines in our own system, reviewing the literature about treatment of disorders, and reviewing guidelines from professional organizations. Guidelines are drafted and then reviewed by Medical Directors. The Medical Directors then submit the guidelines to the Medical Affairs Committee (MAC) with a recommendation that it approve the guidelines. The MAC makes the final decision to approve and adopt the guidelines.

Current clinical position papers

- Medication Assisted Treatment Guidelines for Substance Use Disorders
- Criteria and Guidelines for Authorization of Psychological and Neuropsychological Testing
- Criteria and Standards for Utilizing Single Case Agreements
- Harm Reduction in Substance Use Disorder Treatment
- Ketamine Use for Treatment Resistant Depression or Post-Traumatic Stress Disorder
- Treatment of Highly Specialized Populations
- Utilization of Intranasal Spray of Spravato (esketamine) for Treatment of Treatment- Resistant Depression
- Wilderness Program Treatment

Current treatment guidelines

- Medical necessity
- When a therapist is seeing more than one family member at a time in outpatient treatment
- When a therapist is seeing a member more than once weekly in outpatient treatment
- Dual/multiple relationships with patients
- CMS national and local coverage determinations

A hard copy of these documents may be obtained by calling Behavioral Health Provider Services or accessing the Health Net website.

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 of California Quality Improvement Health Equity Committee (HNCA QIHEC), Health Net Community Solutions Quality Improvement/ Health Equity Committee (HN CS QIHEC), 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 and Health Equity Transformation Program

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

The Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to monitor, evaluate, and take effective action to address any needed improvements in the quality and equity of care.The program applies to all covered services delivered to Health Net members, regardless of whether those services were delegated to a subcontractor, downstream subcontractor, or network provider. The QIHETP is continuous.

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

1) clinical quality of physical health care;

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

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

4) availability and regular engagement with PCP;

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

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

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

The purposes and goals of the QIHETP are to:

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

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

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

Quality Improvement Program and Compliance and HEDIS

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

Health Net tracks and monitors quality of care and service in a number of ways, including through the Healthcare Effectiveness Data and Information Set (HEDIS®). The National Committee for Quality Assurance (NCQA), a not-for-profit organization, created and maintains HEDIS to assess, report on and improve the quality of care and service provided by organized health care delivery systems. HEDIS 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 multiple quality improvement organizations, including:

- California Quality Collaborative (CQC): a healthcare collaborative that seeks to improve clinical care and service for all Californians by providing strategies at the point of care. CQC programs are available to providers to improve chronic disease care, patient satisfaction, and care efficiency. For a listing of educational programs and patient satisfaction and condition management resources visit www.calquality.org.
- The Leapfrog Group: a nonprofit organization dedicated to promoting transparency, safety, and quality in healthcare. Health Net purchases The Leapfrog Group data, and promotes their ratings and standards to network hospitals, members, and the community.
- Cal Hospital Compare: a nonprofit organization providing public performance ratings for a multitude of California hospitals. Health Net contracts with Cal Hospital Compare to obtain Poor Performer and Honor Roll reports and data files to help 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, if indicated, are submitted to the peer review committee (PRC) for appropriate resolution. At a minimum annually, the number, severity, actions taken, and trends noted are aggregated and reported to the Quality Improvement & Health Equity Committee (QIHEC).

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.

Health Net has seven calendar 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 Department of Managed Health Care (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, 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
- Care Manager
- NICU Levels of Care Criteria
- Palliative Care Services

Overview

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

Health Net's care management program is available to all members to:

- Create a comprehensive system of medical management,
- Use resources and managed health care expertise collaboratively, and
- Provide a full complement of coordinated cost-effective care.

The Health Net care management program provides individualized assistance to members experiencing complex, acute or catastrophic illnesses. The focus is on early identification of and engagement with high-risk members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs and improve health and functional status, resulting in favorable outcomes.

Health Net's care management program uses qualified nurses, social workers and medical directors to provide a fully integrated network of programs and services for the management of high-risk, chronic and catastrophically ill or injured individuals.

High and moderate risk Special Needs Plans (SNPs) members who are actively engaged are managed by the health plan’s case manager in order to implement their individual care plan which is designed to support the member’s optimal level of wellness.

Program Goals

The Health Net care management program goals are to achieve, in collaboration with providers, the following:

- **Quality health outcomes** - Identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.
- **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 to careconnections@healthnet.com. 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).

Refer to the Medi-Cal referral process for D-SNPs members.

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 (EPSDRT) 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.

Health Net uses both externally and internally developed criteria for reviewing cases. These criteria create consistency in decision-making by evaluating patient-specific behaviors and symptoms to help make clinically appropriate decisions.

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.

Behavioral Health Providers

Behavioral health decisions are based on nonprofit professional association for the relevant clinical specialty including the criteria and guidelines set forth by the American Psychological Association (APA) Guidelines for Psychological and Neuropsychological Testing and the World Professional Association for Transgender Health (WPATH) criteria.

Health Net has implemented the use of the Level of Care Utilization System and Child and Adolescent Level of Care Utilization System (LOCUS/CALOCUS), and the Early Childhood Service Intensity Instrument (ECSII) criteria for all non-ABA (Applied Behavioral Analysis) mental health medical necessity determinations and level-of-care placement decisions.

For ABA decisions, the medical necessity criteria for Medi-Cal patients includes information on the adoption of clinical policy CA.CP.BH.104 Applied Behavior Analysis (ABA). This change supports more individualized, needs-based care for patients under age 21 by promoting developmental, behavioral and functional improvements for them and their families. For substance use disorder utilization management, Health Net uses the American Society of Addiction Medicine (ASAM) criteria set.

For outpatient testing for drugs of abuse, he medical necessity criteria for Medi Cal patients include information on the adoption of clinical policy HNCA.CP.MP.542, Outpatient Testing for Drugs of Abuse.

When the requested service is not in scope for LOCUS/CALOCUS, or another nonprofit professional association for the relevant clinical specialty, Health Net utilizes internal criteria that have been developed according to generally accepted standards of mental health and substance use disorder care.

By using nationally recognized and evidence-based criteria, our Utilization Managers apply objective, evidence-based standards to support their decisions regarding procedures, levels of care, and continued stay. Supporting appropriate care decisions can lead to better outcomes for our members.

Health Net evaluates each member's plan of treatment for appropriateness and timeliness. It is Health Net's policy to share specific level of care guidelines and utilization management review procedures in writing with providers, members, customers, and members of the general public who request them.

Copies of criteria can be obtained by providers and members by calling the specific number listed on the back of the member's ID card.

Continuity of Care

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

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization. For any concurrent authorization that is denied, care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The Transitional Care Services program is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Members have the right to:

- Be informed of continuing health care requirements following discharge from the hospital or inpatient facility.
- Be informed that, if the member authorizes, a friend or family member may be provided information about the member's continuing health care requirements following discharge from the hospital or inpatient facility.
- Actively participate in decisions regarding medical care. To the extent permitted by law, participation includes the right to refuse treatment.
- Appropriate pain assessment and treatment.

Electronic medical records or administrative system (Medi-Cal providers only)

In accordance with the Provider Participating Agreement (PPA) and Federal regulation 42 CFR 482.24 section (d), hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

- Los Angeles Network for Enhanced Services (LANES)
- Manifest MedEx
- SacValley MedShare
- San Diego Health Connect
- Applied Research Works, Inc.
- Health Gorilla, Inc.
- Long Health, Inc.
- Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
- Serving Communities Health Information Organization (SCHIO)

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 Behavioral Health 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 Behavioral Health 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.

Behavioral Health Concurrent Review

- The attending physician or facility utilization review staff calls the Health Net Utilization Review Clinician on the agreed-upon review date and provides and verifies the concurrent review information.
- The Utilization Review Clinician obtains all of the following information required for concurrent review via phone with the utilization review staff or attending psychiatrist at the facility:
    - Diagnosis
    - Symptom progress/change in severity
    - Risk areas
    - Treatment goals/interventions
    - Medications
    - Indicators for continued treatment
    - Discharge planning (to begin at the time of admission)
    - Target discharge date
    - Other clinical information, as needed

Providers must notify the Health Net Utilization Review Clinician via phone on the same day that the member is discharged and provide a detailed discharge summary within 24 hours. The discharge summary must include information about the member’s status at discharge, such as current symptoms and medications, details about post-discharge appointment(s) scheduled for step-down care, and the member’s updated contact information (i.e., address, phone number).

- The Utilization Review Clinician reviews clinical data and authorizes additional days if medical necessity criteria for a continued stay are met.
    - If the medical director denies authorization, refer to the non-certification procedure.
    - If medical necessity criteria for a continued stay are not met for the level of care requested, the Utilization Review Clinician will review the request with a Health Net medical director.
    - If the medical director denies authorization, refer to the non-certification procedure.
    - The Utilization Review Clinician documents clinical appropriateness.
    - The Utilization Review Clinician consults with a clinical manager and/or a medical director when any aspect of the treatment plan is unclear or in question.

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.

Behavioral Health Noncertification

For most health plans, requesting facilities are notified by phone immediately of the review decision.

1. The Health Net Utilization Review Clinician receives requests for initial authorization from the clinical contact at the facility or program by online submission, via the Availity Essentials secure provider portal, fax or phone. The Health Net Utilization Review Clinician receives any subsequent requests for continued stay from the clinical contact by phone.
2. Administrative denials (based on exhaustion of benefits, lack of pre-authorization, etc.) do not require Health Net medical director review.
3. When medical necessity criteria do not appear to be met, the Utilization Review Clinician presents the case to the medical director for review. In some clinical denials, the facility is notified by the Utilization Review Clinician that they can request a peer-to-peer discussion with the peer reviewer who originally denied the authorization. If the denial decision is not changed following peer-to-peer review discussion and the patient or facility still disagrees with the determination, the patient or patient's representative (often the facility) can request an appeal by a different peer reviewer if the patient is still in treatment.
4. Notification of denial of authorization is typically made by phone immediately, but not longer than permitted based on the type of account. For urgent concurrent requests, written confirmation is sent within 24 hours of receipt of request.
5. The original denial letter is sent to the patient and copies are sent to the facility, parent and/or guardian (if applicable) and attending physician. The denial letter will always include the rationale for the denial decision and a full description of the appeals procedure.

In case of inpatient treatment services where the member is still hospitalized, a practitioner who wishes to appeal a denial immediately on behalf of the member is verbally notified of the urgent/expedited appeals process, in which the facility representative (e.g., attending physician) can speak with another peer reviewer to present the case.

All service requests that do not meet medical necessity approval criteria as described herein, or where medical necessity is questionable or unclear, must be reviewed by a Health Net medical director.

Notification of Hospital Admissions

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

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

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

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

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

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).
- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number.
- For obstetrical (OB) delivery admissions, include newborn sex, weight, apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

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

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

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

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

Requests for post-stabilization authorization

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

The hospital’s request for authorization is required once the Health Net member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for inpatient post-stabilization care. A patient is “stabilized,” or “stabilization” has occurred, when, in the opinion of the treating provider, the

patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

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

How to request post-stabilization authorization

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

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

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

Failure to request post-stabilization authorization

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

Required documentation

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

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

Conditions of financial responsibility

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

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

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

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

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

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

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

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

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

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

How to Request Behavioral Health Post-Stabilization Authorization

To request authorization for post-stabilization care, the hospital must call the hospital or facility admissions office.

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

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

Behavioral health emergencies

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

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

Response time to requests

The Plan must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If a response to approve or disapprove the request is not provided within 30 minutes, the post-stabilization care request is considered authorized. This applies to any participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

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

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 Contact Information

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 Overpayment Recovery Department
- Health Net Provider Communications Department
- Health Net PPO Claims Submission
- Health Net - Prior Authorization
- 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

- Mahmee
- 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

Contacts

This section contains general contact information for providers.

AcariaHealth

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

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

Access to Interpreter Services

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

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

Medi-Cal

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

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

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

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

Medi-Cal Interpreter Services

Member Plan	Hours of Availability	Contact Number	Required Information
Medi-Cal (Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne)	24 hours a day, 7 days a week	800-675-6110	Member name and Health Net ID number, appointment date and time
Medi-Cal/CalViva (Fresno, Kings and Madera)	24 hours a day, 7 days a week	888-893-1569	Member name and the Plan ID number, appointment date and time
Medi-Cal/Community Health Plan of Imperial Valley	24 hours a day, 7 days a week	833-236-4141	Member name and the Plan ID number, appointment date and time

HMO, Medicare Advantage HMO, PPO

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

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

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

Commercial Interpreter Services

Line of Business	Phone Number	Hours of Availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)

Line of Business	Phone Number	Hours of Availability
Employer Group HMO, POS and PPO	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays

Medicare Interpreter Services

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

AIDS Waiver Program

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

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

Kern

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

Kings

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

Los Angeles

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



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

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

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

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

Madera

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

Riverside

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

Sacramento

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

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

San Bernardino

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

San Diego

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

San Joaquin

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

health net

Stanislaus

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

Alcohol and Drug Treatment Services

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

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

Amador

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

Calaveras

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

Fresno

Fresno County Alcohol and Drug Program 559-493-2185

Inyo

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

Kern

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



Kings

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

Los Angeles

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

Madera

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

Mono

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

Sacramento

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

San Diego

Office of Alcohol and Drug Programs 888-724-7240

San Joaquin

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

Stanislaus

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

health net

Tulare

Alcohol and Drug Treatment 559-636-4000

American Specialty Health Plans

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

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HMO, Medicare Advantage HMO, and PPO

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

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

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

April–September

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

October–March

7 days a week, 8 a.m. – 8 p.m. PT

For more information, visit the American Specialty Health website.

Medi-Cal

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

800-972-4226, option 2.

Animas Diabetes Care LLC

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

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

Apria Healthcare Inc

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

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

800-277-4288

ATG Rehab Specialists Inc

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

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Provider of rehabilitation equipment services.

877-489-3651

Byram Healthcare Centers, Inc.

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

Byram Healthcare Centers, Inc.

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

Byram Healthcare website

Behavioral Health Contact Information

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

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Behavioral Health Function	Description and/or Contact
Claims inquiries or questions	Behavioral Health Provider Services **Phone**: 844-966-0298
Eligibility and benefit checks	• Availity Essentials Provider Portal ◦ Technical Support Phone: 800-282-4548 (Monday–Friday, 5 a.m.–5 p.m. Pacific time). • Health Net Provider Portal ◦ Technical Support Team Phone: 866-458-1047.
Prior authorization	Submit initial prior authorization requests for all facility-based behavioral health services as outlined below. Concurrent reviews will continue with the assigned Utilization Review Clinician. **Commercial and Medicare (Ambetter HMO/PPO, Employer Group HMO/POS, and Wellcare By Health Net members)** • **Online**: Availity Essentials secure provider portal • **Fax**: 855-663-2244 • **Phone**: 844-966-0298 For transcranial magnetic stimulation (TMS), ABA or neuropsychological testing, submit via fax at: • **TMS**: 855-661-0077 • **ABA**: 855-427-4798 • **Neuropsychological testing**: 855-703-3268 **Medi-Cal** Call 844-966-0298 for assistance.
Update provider data	Providers directly contracted with Health Net can refer to the Participating Provider Operations page for detailed

Behavioral Health Function	Description and/or Contact
	instructions. Providers contracted under a PPG can contact their PPGs to update this information.
Provider disputes	Submit using the Behavioral Health Provider Appeal/ Dispute Form (PDF).
Request a copy of your contract	Behavioral Health Provider Services **Phone**: 844-966-0298
Contract renegotiation	Send a request via email to DNBHC@healthnet.com

California Department of Health Care Services Subacute Contracting Unit

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

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

California Children's Services Paneling Inquiries

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

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Paneling Inquiries:

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

California Department of Social Services State Fair Hearing

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

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

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

California Children's Services Program

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

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

Amador

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

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

Calaveras

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

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

Fresno

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



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

Imperial

935 Broadway Street El Centro, CA 92243-2396

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

Inyo

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

Kern

1800 Mt. Vernon Avenue Bakersfield, CA 93306

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

Kings

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

Los Angeles

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

Madera

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

Mono



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

Riverside

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

Sacramento

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

San Bernardino

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

San Diego

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

San Joaquin

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

209-468-3900
Fax 209-953-3632

Stanislaus

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

Tulare

1062 South K Street Tulare, CA 93274 559-687-6915



Fax: 559-713-3740

Tuolumne

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

CalViva Health Medi-Cal Member Services Department

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

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

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

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

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

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

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

CalViva Health Medi-Cal Provider Services Department

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

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

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

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

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

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

Eligibility and claims status available online.

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

CalViva Health Nurse Advice Line

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

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The CalViva Health Nurse Advice Line program provides 24-hours a day, 7 days a week triage or screening services by phone. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment, and advice. The CalViva Health Medi-Cal Member Services Department coordinates member access to the CalViva Health Nurse Advice Line, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, provide self-care guidance, general health information, or recommend a visit to urgent care or the ER. Nationally recognized triage guidelines are used to determine the level of care needed by the member.

Health Net ensures that Nurse Advice Telephone Triage & Screening program services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

Role of the Program Nurse

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members who need urgent care are referred to an urgent care center if the PCP is not available.

The nurse educates the member on the role of the PCP and gives the member care advice instructions to care for their symptoms at home until they receive care from the PCP.

Each time a member calls into the nurse advice line, the care is documented in the member’s chart with a report sent to the member’s health plan advising them of the care sought and the disposition offered.

888-893-1569

Cancer Information Services

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

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

800-422-6237

Care Ride Unit

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



Phone: 833-236-9695

Fax: 833-701-0051

Case Management Department

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

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Contact the Case Management Department at:

Commercial

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

Medi-Cal

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

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

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

- 800-675-6110 if the member has a Health Net Medi-Cal plan.
- 833-236-4141 if the member has a CHPIV Medi-Cal plan.
- 888-893-1569 if the member has a CalViva Health Medi-Cal plan.

Centers for Medicare & Medicaid Services

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

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The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the Department of Health and Human Services that governs the Medicare, Medicaid, Clinical Laboratories (under CLIA program), and

Children's Health Insurance programs to help ensure that eligible beneficiaries in these programs are able to get high-quality health care.

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

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

Centene Vision Services

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

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

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

Centralized Transplant Unit

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

Fax numbers for organ transplant reviews and authorizations:

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

Children's Medical Services

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

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

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

Communicable Disease Reporting

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

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

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

Amador

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

Calaveras

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

Fresno

Communicable Disease Control County of Fresno 1221 Fulton Mall P.O. Box 11867 Fresno, CA 93775
559-445-3324
Fax: 559-445-3535

Imperial

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



Inyo

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

Kern

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

Kings

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

Los Angeles

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

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

Long Beach Health Department 562-570-4000

Pasadena Health Department 626-744-6005

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

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

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

Madera

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

Mono



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

Sacramento

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

San Diego

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

San Joaquin

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

Stanislaus

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

Tulare

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

Tuolumne

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

Community-Based Adult Services Centers

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

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

Licensed CBAS centers include the following:CBAS Providers - Community-Based Adult Services - Providers & Partners | California Department of Aging - State of California

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

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

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Providers must submit all Community-Based Adult Services (CBAS) requests, including requests for a face-to-face assessment, by submitting the CBAS Treatment Request Form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF). Providers can also submit request through the Health Net provider portal. Once logged in, go to the member's profile and select *Assessments* . Select *Fill Out Now!* next to CBAS Treatment Request.

Comprehensive Perinatal Services Program

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

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

Amador

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



Calaveras

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

Fresno

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

Imperial

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

Inyo

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

Kern

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

Kings

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

Los Angeles

Los Angeles 213-639-6419

Long Beach 562-570-4060

Madera

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

Mono

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

Riverside

951-358-5438

Sacramento

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

San Bernardino

800-227-3034

San Diego

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

San Joaquin

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

Stanislaus

Stanislaus County Health Services Agency

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

Tulare

559-685-2275

Tuolumne

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

Connect Hearing Inc

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

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888-608-7462

Connect Hearing website

County Mental Health Plan

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

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

County Mental Health Plan Contact Information

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

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

County Relations/Service Coordination

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

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

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

Coram

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

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Health Net's preferred infusion provider

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

Custom Rehab Network

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

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Provider of custom rehabilitation equipment services.

800-276-6557

Community Health Plan of Imperial Valley Member Services Department

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

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

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

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

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

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

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

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

Community Health Plan of Imperial Valley Provider Services Department

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

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

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

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

The Community Health Plan of Imperial Valley Medi-Cal Provider Services Department toll-free telephone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Community Health Plan of Imperial Valley Provider Services Department Phone Number: 833-236-4141

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

Eligibility and claims status available online.

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

Community Health Plan of Imperial Valley Nurse Advice Line

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

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The Community Health Plan of Imperial Valley Nurse Advice Line program provides 24-hours a day, 7 days a week triage or screening services by phone. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP.

According to Health Net's community access-to-care standards, all PCPs must provide 24-hour phone service for urgent/emergent instructions, medical condition assessment, and advice. The Community Health Plan of Imperial Valley Medi-Cal Member Services Center coordinates member access to the Community Health Plan of Imperial Valley Nurse Advice Line, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, provide self-care guidance, general health information, or recommend a visit to urgent care or the ER. Nationally recognized triage guidelines are used to determine the level of care needed by the member.

Health Net ensures that Nurse Advice Telephone Triage & Screening program services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

Role of the Program Nurse

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members who need urgent care are referred to an urgent care center if the PCP is not available.

The nurse educates the member on the role of the PCP, , and gives the member care advice instructions to care for their symptoms at home until they receive care from the PCP.

Each time a member calls into the nurse advice line, the care is documented in the member’s chart with a report sent to the member’s health plan advising them of the care sought and the disposition offered.

833-236-4141

Delta Dental

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

855-643-8515

April–September
Monday through Friday
8 a.m. – 8 p.m. Pacific time (PT)

October–March
7 days a week
8 a.m. – 8 p.m. PT

Dental Benefit Providers

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

866-249-2382

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

October–March
7 days a week
5 a.m. – 8 p.m. PT

Denti-Cal

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

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Medi-Cal members are entitled to annual dental screenings, as described in the periodic health exam schedules. Primary care physicians (PCPs) refer members for dental services to Medi-Cal dental providers.

800-322-6384

Department Of Health Care Services

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

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The sterilization informational brochures are available online for downloading and printing. California Department of Health Care Services (DHCS)

Department of Insurance

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

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The Department of Insurance (DOI) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use Health Net's grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DOI. Providers, including participating physicians, may assist the member in submitting a complaint to the DOI for resolution and may advocate the member's position before the DOI. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

800-927-4357
213-897-8921

Department Of Managed Health Care

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

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The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use the grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DMHC. Providers, including participating physicians, may assist the member in submitting a complaint to the DMHC for resolution and may advocate the member's position before the DMHC. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

888-466-2219
800-400-0815
TTY: 877-688-9891

Contact DMHC

Department Of Social Services (DSS)

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

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The Department of Social Services (DSS) Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding fair hearings and grievances.

PO Box 944243 Mail Stop 19-37 Sacramento, CA 94244-2430

800-952-5253
TTY: 800-952-8349
Fax: 916-229-4110

Electronic Claims Clearinghouse Information

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

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Submit electronic claims for Health Net members to the appropriate clearinghouse:

Clearinghouse Information

CLEARINGHOUSE	PHONE NUMBER	WEBSITE	HEALTH NET PAYER ID NUMBER
Change Healthcare (fee-for-service only)	877-469-3263 or 800-792-5256	client-support.changehealthcare.com	68069 (Medicare and Individual Family Plans including Covered California) 95567 (Medi-Cal and Commercial)
Transunion (capitated encounters only)	Your account manager or 310-337-8530	www.transunion.com	95568 and 95570

The payer ID must be included with every claim.

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse.

EviCore Healthcare

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

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eviCore healthcare is responsible for prior authorization for select sleep and radiation therapy services.

Sleep

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: 866-999-3510

Radiation therapy

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: Radiation Therapy: 800-540-2406

Evolent Specialty Services, Inc.

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Evolent Specialty Services, Inc. (Evolent), formerly known as National Imaging Associates, Inc. (NIA), is responsible for prior authorization for advanced imaging services and cardiac imaging.

Prior authorization requests must be submitted to Evolent online or by phone as follows. Evolent does not accept fax submissions.

www.RadMD.com (24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours)

Evolent Specialty Services Contact Information

PRODUCT	HOURS OF OPERATION	PHONE NUMBER
Commercial	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4802
Medi-Cal	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4809

EyeMed Vision Care

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Health Net is contracted with Centene Vision Services to provide vision benefits to Health Net members for some plans. Centene Vision Services sub-delegates benefit administration to EyeMed. EyeMed provides benefits for routine vision exams and eyewear through their network of optometrists, dispensing opticians and optometric laboratories.

Benefit administration for the routine vision examination varies by plan/product. Please verify coverage to determine if an appointment for a vision examination is covered through the participating physician group (PPG) or through EyeMed.

EyeMed Vision Care
Health Net Vision
4000 Luxottica Place
Mason, OH 45040

866-392-6058

Third Party Risk Management Office

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

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The Third Party Risk Management Office (TPRMO) is responsible for tracking and monitoring the financial solvency of delegated providers. Contact them for assistance to submit quarterly financial updates or statements and for questions.

email: financeoversight-pa@healthnet.com

Health Care Options (HCO)

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

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The Health Care Options (HCO) contractor processes Medi-Cal managed care enrollments and disenrollments. Refer members to the appropriate toll-free number for assistance.

Arabic 800-576-6881

Armenian 800-840-5032
Cambodian 800-430-5005

Cantonese 800-430-6006

English and other languages 800-430-4263

Farsi 800-840-5034

Hmong 800-430-2022

Korean 800-576-6883

Laotian 800-430-4091

Mandarin 800-576-6885

Russian 800-430-7007

Spanish 800-430-3003

Tagalog 800-576-6890

Telephonic device for the deaf and hearing impaired 800-430-7077

Vietnamese 800-430-8008

Health Net Care Management Department

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

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Health Net offers transition of care assistance that allows members who are receiving care to continue with their established non-participating provider. Approval decisions are based on individual review of member's care needs in relation to benefits and regulatory requirements.

- Medicare Case Management: 800-977-7915
- Commercial Case Management: 888-732-2730

Health Net Claims Submission

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

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Claims address for HMO products.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Continuity and Coordination of Care Department

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

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Participating physician groups (PPGs) must immediately forward all pertinent documentation for investigational or experimental treatment for a terminal illness via fax or by overnight mail.

Fax: 866-295-4780

Health Net of California, Inc.
Continuity and Coordination of Care
Medical Management Department
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Credentialing Department

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

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The Health Net Credentialing Department is responsible for credentialing and recredentialing directly contracting providers and all providers affiliated with participating physician groups (PPGs) to which credentialing responsibilities have not been delegated. The Health Net Credentialing Department also oversees delegated and subcontracting credentialing activity.

20151 Nordhoff
Chatsworth, CA 91311
Fax: 800-655-4128

Health Net's Health and Wellness Referral Fax

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

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To refer a Health Net member to one of the programs for disease management, case management or complex case management, fax a referral to 800-745-6955 or 678-355-4018 for pregnancy notification only.

You can also email a referral fax.

Delegation Oversight Department

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

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The Health Net Delegation Oversight Department (previously Provider Oversight Department) oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies. The department conducts on-site due diligence evaluations prior to Health Net agreeing to contract with a provider and through on-site evaluations at least annually thereafter. Based on these evaluations, the Health Net Delegation Oversight Committee (DOC) determines which functions are to be delegated to the participating physician group (PPG). The Health Net DOC measures, monitors and oversees compliance of providers and requires corrective actions when deficiencies are discovered. The DOC is a multi-disciplinary committee comprised of, but not limited to, members from Health Net's Delegation Oversight, Health Care Services, Network Management, Medical Management, Finance Departments, and State Health Programs. If the prescribed three-step corrective action process with progressive sanctions does not resolve the deficiency, delegation may be revoked and the provider's contract terminated.

Coalition Reports

Program Accreditation Department
21281 Burbank Blvd., 5th Floor
Woodland Hills, CA 91367

Fax: 866-476-0311 provider.oversight@healthnet.com

Email the Delegation Oversight Group at Delegation_Oversight_Group@CENTENE.COM for any questions about access or users.

Health Net EDI Claims Department

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

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For questions on electronic claims or electronic remittance advice for Individual Family Plan (IFP), Medicare Advantage (MA) HMO member claims, contact:

Centene EDI Department

800-225-2573, extension 6075525

Or by email at EDIBA@centene.com

The following providers can continue to contact Health Net EDI department by phone at 800-977-3568 or by email at edi.support@healthnet.com

- California, MA HMO employer group, HMO, PPO (including EnhancedCare PPO for small business group), POS, and Medi-Cal (including CalViva Health)

Health Net Elect Claims

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

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Claims address for the Health Net Elect Point-of-Service (POS) product.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net Encounter Department

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

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Contact the Health Net Encounter Department via email for encounter data questions.



Enc_Group@healthnet.com

Health Net Enrollment Services Department

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

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For general questions regarding eligibility and enrollment, contact the Health Net Enrollment Services Department Monday through Friday, from 7:30 a.m. to 7 p.m. at:

800-327-0502

Health Net Facility Site Review Compliance Department

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

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The Health Net Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-on-one education and support of providers.

The Health Net FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staffs in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

21281 Burbank Blvd., Woodland Hills, CA 91367 209-943-4803
Email: Facility.site.review@healtlhnet.com

Health Net Fraud Hotline

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

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Health Net is serious about finding and reporting fraud, waste or abuse (FWA). To report suspected FWA, please contact the Special Investigations Unit at one of the following:

Phone: 866-685-8664. The toll-free Fraud, Waste & Abuse Hotline is answered by an independent third party and is available 24 hours a day, 7 days a week.

Email: Special_Investigations_Unit@centene.com

Mail: Centene Special Investigations Unit7700 Forsyth Blvd 5th floor, Room 519, Clayton, MO 63105

Reports of suspected FWA may be made anonymously.

Health Net Health Education

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

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Medi-Cal Counties

Fresno, Kings, Madera

The Health Education System promotes resources and programs to educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

CalViva Health education programs, services and resources are available at no cost to CalViva Health Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting the Member Services at 888-893-1569. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

7625 N. Palm Suite #107 Fresno, CA 93721 888-893-1569
Fax: 800-628-2704

Amador, Calaveras, Imperial, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne

The Health Net Health Education educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

Health education programs, services and resources are available at no cost to the Plan's Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting Member Services at 800-675-6110. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

21281 Burbank Boulevard Woodland Hills, CA 91367 800-675-6110

Fax: 800-628-2704

Health Education programs and services include:

- Member Services Line. Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, and exercise. These materials are available in several threshold languages. Direct members to call their respective Member Services line.
- Tobacco Cessation Program. Kick It California is a no-cost, statewide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers:
    - **Telephonic Quit Coaching**:
        - Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
        - Tailored quit plan to member's unique circumstances.
        - Available Monday – Friday 7 a.m. – 9 p.m., Saturday 9 a.m. – 5 p.m.
        - To enroll, members may use the online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

        - **Automated Texting Program:**
            - Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within two business days.
            - Text "Quit Smoking" or "Quit Vaping" to 66819.
            - Texto "Deje de Fumar" o " No Vepear" al 66819.
        - **Chat with a Quit Coach**
            - Kickitca.org/chat
            - Alternative option for both members and health care providers.
            - Platform allows members quick responses to inquiries such as available services and free nicotine patch evaluation.
            - Health care providers may use the chat to find answers to cessation-related questions.
            - Available in English only, Monday – Friday, 7 a.m. – 9 p.m., and Saturday 9 a.m. – 5 p.m.
        - Mobile App:
            - Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
            - Features tools such as a personal log of smoking triggers, motivational reminders and links to helpful resources.
            - Available for download on the App Store® and Google Play®
            - Visit Kick It California for more details
- Digital Health Education - members have access to online and digital resources for health education through our Krames Staywell health library – Resource library to help you learn about your health and how to stay healthy.
    - Health and Medications – Easy access to more than 4,000 health sheets.
    - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.

  The Teladoc Mental Health Digital Program website and mobile application offers clinically-proven mental health resources to help members manage depression, anxiety, stress, substance use, and pain management.
- Health Education Classes. Members may access health education classes on a variety of health topics, such as diabetes, asthma, healthy eating, oral health, heart health, fitness, and prenatal

care. Members can request a schedule of upcoming health education classes by calling their respective Member Services phone line.
- Member Incentive Programs - Incentive programs for members allow eligible individuals to engage in activities aimed at promoting behavioral change, such as health screenings, preventive health appointments, and health education initiatives, in exchange for rewards. Health Net will notify members who are eligible to participate.
- Provider Resources. Physicians may order health education materials online by using the Health Education Material Order Form.

21281 Burbank Boulevard Woodland Hills, CA 91367
Fax: 800-628-2704

Health Net Health Equity Department

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

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The Health Net Health Equity Department promotes access to care for members who speak a primary language other than English. The department is responsible for developing, implementing and monitoring processes to meet regulatory requirements. The department assesses the cultural and language needs of members and encourages provider, community advocate, and member input through ongoing communication and by participation in county-specific Community Advisory Committees. This helps ensure that materials and interpreter services are available in the member's language, while taking into consideration the member's cultural background in the development of member materials.

The Health Net Health Equity Department has a number of internal processes to enhance services to Health Net's non-English speaking members, including:

- Tracking the interpretation needs of members.
- Monitoring population and membership language distribution for trends.
- Monitoring the availability of materials translated into threshold languages.
- Assessment of language capabilities of the existing provider network and recommendations to the Health Net Provider Network Management staff for network development.
- Review of translations of member materials, such as the Evidence of Coverage (EOC), provider directories, marketing materials, form letters, health reminders, member surveys, newsletters, and health education materials.
- Providing in-service trainings, workshops and educational opportunities to Health Net staff on the linguistic needs and cultural background of Health Net members.
- Supporting Health Net participating providers with information and material on the cultural background, linguistic needs and health care concerns of Health Net members.
- Gathering feedback from providers, the community and members using surveys and focus group studies on cultural and linguistic needs.
- Monitoring and tracking cultural or linguistic related member grievances to gain an understanding of issues impeding member access to care.

Contact the Health Net Health Equity Department for more information at Cultural.and.Linguistic.services@healthnet.com



Commercial: 800-977-6750
Medicare: 800-546-4570

Fax: 818-543-9188

For written translation assistance services, contact the appropriate Provider Services Center:

Line of Business	Phone Number	Hours of Availability
Large Employer Group	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (off exchange)	800-361-3366	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (on exchange)	888-926-5133	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (off exchange)	877-857-0701	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (on exchange)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time
Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m. Pacific time

Line of Business	Phone Number	Hours of Availability
After hours Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110, select the member option	6 p.m. to 8 a.m. Pacific time, weekends and holidays
Medi-Cal/CalViva Health (Fresno, Kings and Madera)	888-893-1569	24 hours a day, 7 days a week
Medi-Cal/Community Health Plan of Imperial Valley	833-236-4141	24 hours a day, 7 days a week

Health Net Hospital Notification Unit

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

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Post-stabilization authorization request: call 800-995-7890 to provide notification.

Hospitals are required to contact the Health Net Hospital Notification Unit (HNU) within 24 hours of an admission (or one business day when an admission occurs on a weekend or holiday) for a Health Net member via phone, fax or website.

Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITES
• Employer group Medicare Advantage (MA) HMO • Employer group HMO, POS, PPO, (includes EnhancedCare PPO Small Business Group (SBG)) • Medi-Cal	Fax: 800-676-7969	provider.healthnetcalifornia.com

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITES
• Individual MA HMO and Special Needs Plan (SNP) (does not apply to MA HMO employer groups)	Fax: 844-825-8045	provider.healthnetcalifornia.com

For Individual & Family Plans (IFP) members (Ambetter HMO and Ambetter PPO), hospitals are required to contact the HNU within 24 hours or one business day, via fax or by web, when an admission occurs on a weekend.

IFP Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITE
• IFP Ambetter HMO • IFP Ambetter PPO	Fax: 844-760-8992	provider.healthnetcalifornia.com

Health Net
Attention: Hospital Notification Unit
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Long-Term Care Intake Line

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

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Providers should contact the Health Net Long-Term Care Intake line via fax to notify Health Net of its Medi-Cal members' admissions to long-term nursing facilities.

Fax: 855-851-4563

800-453-3033 - to check the status of your request

Health Net Mail Order Prescription Drug Program

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

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HMO and PPO

For commercial [non-Individual and Family Plan (IFP)] plans, use **CVS:**

New prescription medication requests may be mailed by the member or faxed to CVS by the prescribing physician. The member's identification number, date of birth, telephone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

CVS Caremark
PO Box 94467
Palatine IL 60094-4467
Fax: 800-378-0323

For on/off-exchange Ambetter HMO/PPO plans, use **Express Scripts® Pharmacy:**

The prescribing physician can send requests for new prescriptions to Express Scripts Pharmacy via **fax to 800-837-0959** or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx.

Medicare Advantage HMO

The prescribing physician can send requests for new prescriptions to **Express Scripts Pharmacy** via **fax to 800-837-0959** or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx. The member's identification number, date of birth, phone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

Note: For Employer Group Retiree Drug Subsidy (RDS) members, use CVS Caremark mail order service.

Health Net Marketing Department

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



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Prior to using, distributing or displaying marketing materials directed to Medicare-eligible beneficiaries, participating providers are required to send these materials for approval to the Health Net Marketing Department, Attention: Medicare Marketing Director.

MedicareMktgReview@healthnet.com

Health Net Medi-Cal Claims

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

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Address for written correspondence regarding claims, tracers, adjustment requests, or denial reconsideration. Health Net Community Solutions, Inc. Medi-Cal Claims PO Box 9020 Farmington, MO 63640-9020

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medi-Cal Facility Site Review Compliance Department

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

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The Health Net Medi-Cal Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-to-one provider education and support.

The Health Net Medi-Cal FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staff in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

Phone: 209-403-9310

Fax: 877-779-0753

Health Net Medi-Cal Medical Management Department

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

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The Health Net Medical Management Department conducts concurrent review of inpatient cases and coordinates care for members under the care management program. Contact the Health Net Prior Authorization Department to request prior authorization or assistance with referrals. Participating physician groups (PPGs) may contact the Medical Management Department for assistance with member case management. Providers affiliated with a delegated PPG must follow their PPG's instructions for referrals and requests for prior authorization. All participating providers must inform Health Net immediately when investigational or experimental treatment is requested.

Medi-Cal Member Appeals and Grievances Department

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

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- By phone: Contact Health Net 24 hours a day, 7 days a week by calling 800-675-6110 or 833-236-4141(Imperial County). If you cannot hear or speak well, please call TTY: 711.
- In writing: Fill out an appeal form or write a letter and send it to:

Health Net Medi-Cal Member Appeals and Grievances Department P.O. Box 10348 Van Nuys, CA 91410-0348
Fax: 877-713-6189

Your doctor’s office will have appeal forms available. Your health plan can also send a form to you.

- Electronically

OR

CalViva Health Member Appeals and Grievances Department PO Box 10348 Van Nuys, CA 91410-0348

Fax: 877-831-6019

Health Net Medi-Cal Member Services Department

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

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

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

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

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

The Health Net toll-free number is printed on the back of the member’s identification card 800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Health Net Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Health Net's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Health Net Nurse Advice Line (N24) when applicable.

Health Net Member Services Department Open 24/7

Phone Number: 800-675-6110

You can also visit Member Services online at any time at www.healthnet.com.

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

Medi-Cal Provider Appeals and Grievances - Health Net Medi-Cal and CalViva Health

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

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Address for provider disputes and grievances:

Medi-Cal Provider Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

OR

CalViva Health Provider Disputes and Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

Health Net Medi-Cal Provider Services Department

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

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

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

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

The Health Net Medi-Cal Provider Services Department toll-free phone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Health Net Provider Services Department Phone Number: 800-675-6110, option 2
Fax: 844-837-5947 or 800-281-2999 Provider website

Providers may use HNMedi-cal.ClaimsInquiry@healthnet.com for claim status only if the provider portal is down or not working. This email is only for claim status and denial inquiries.

To disenroll a non-compliant member refer to the Disenrollment section.

Fax or mail the formal letter and all supporting documents to:

Attn: Non-Compliance Unit

Fax: 844-837-5947

Address: PO BOX 10303, Van Nuys, CA 91410-0303

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medicare Advantage Claims Department

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

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Address for Health Net Medicare Advantage (MA) claims.

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medicare Advantage Provider Disputes

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

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Address for Medicare Advantage provider disputes.

Health Net Provider Appeals Unit
PO Box 9030
Farmington, MO 63640-9030

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medicare Appeals and Grievances Department

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

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Although there is a specific post office box for submission of Health Net Medicare member appeals for denied services or other grievance correspondence, Health Net prefers to receive appeals and grievances by fax. This enables Health Net to receive, process and resolve the member's issues quickly in accordance with state and federal timeliness requirements. Member appeal requests must be submitted in writing.

Health Net Medicare Appeals and Grievances Department

Fax: 844-273-2671

PO Box 10450
Van Nuys, CA 91410-0450

800-275-4737

For non-contracted providers, submit your dispute request in writing, along with complete documentation (such as a remittance advice from a Medicare carrier), to support your payment dispute to:

Wellcare By Health Net – Appeals
P.O. Box 3060
Farmington, MO 63640-3822

Health Net Medicare Programs Provider Services Department

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

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To ensure appropriate coverage of medical services for Medicare members, Health Net requires the provision of timely responses and accurate information an absolute necessity. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this issue, Health Net directs inquiries from members and employer groups to the Medicare Programs Member Services Department. Inquiries from participating physician groups (PPGs), hospitals, ancillary providers, and physicians are directed to the Provider Services Department, or the provider relations and contracting specialist (previously known as regional network administrators), where available.

The Provider Services Department telephone number is to be used exclusively by PPGs, hospitals and providers and should not be given to members.

During business hours (Monday through Friday, 8 a.m. to 5 p.m.), Health Net Provider Services Department representatives are available to assist providers with:

- Member eligibility and effective dates, and eligibility research.
- Questions about the Health Net prescription drug program.
- Conflict resolution regarding benefit interpretation.
- Exceptions and administrative decisions.
- Complaints regarding health care services, delivery of health care services or PPG staff.
- Request for removal of members for disciplinary actions.
- PPG transfer requests, other than address change or open enrollment.
- Questions regarding claim status.

Claims address:

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

800-929-9224 for all Medicare individual and Medicare employer group plans

800-641-7761 for all Medicare Supplement plans

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Member Appeals and Grievances Department

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

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Address and telephone numbers for member appeals for denied services or other grievance correspondence.

PO Box 10348

Van Nuys, CA 91410-0348

800-522-0088 for commercial members in Northern California

800-638-3889 for commercial members in Southern California

Fax: 877-831-6019

Health Net Member Services Department

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

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To ensure appropriate coverage of medical services for members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may unintentionally misuse the program, resulting in medical services not being covered. To avoid these problems, member and employer group inquiries are directed to an expert team of associates via the Health Net Member Services Department. This team is responsible for resolving member and employer group issues that have been routed to them via a telephone call, written correspondence or the Internet. The Health Net Member Services Department is responsible for resolving issues pertaining to the following:

- Health Net benefit questions and explanations.
- Education on the access of the health care delivery system.
- Professional and hospital services, bills and claims.
- ChiroNet benefits and eligibility.
- Health Net prescription drug program questions, eligibility and claims.
- EyeMed Vision Care program questions about eyewear benefits, eligibility and claims.
- Membership problems and inquiries.
- Member updates (includes adding and deleting members, address changes, PCP/PPG changes).
- Contract cancellation requests.
- Conversion.
- Identification card requests.

Health Net Member Services Department
PO Box 9103
Van Nuys, CA 91409-9103
800-522-0088

Health Net Provider Communications Department

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

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The Health Net National Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, changes in contractual, legislative and regulatory requirements through provider operations manuals, updates, letters, and newsletters. To access the most current information, log on to the provider portal.

4191 East Commerce Way
Sacramento, CA 95834
Mailstop: CA4191-04-167

provider.communications@healthnet.com

Health Net Nurse Advice Line

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

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

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

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

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

800-675-6110

Health Net Overpayment Recovery Department

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

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Address for overpayment refunds and applicable information.

California Medi-Cal and Commercial
Health Net of California
File# 56527
2706 Media Center Dr.
Los Angeles, CA 90074-6527

WellCare by Health Net (Medicare) and **Health Net Marketplace**
Attention: Claims Recovery Team
P.O. Box 886027
Los Angeles, CA 90088-6027

Health Net PPO Claims Submission

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

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Health Net Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net – Prior Authorization

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

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Health Net accepts prior authorization requests for elective and urgent services by fax, phone and online. All participating providers must immediately inform Health Net when there is a request for investigational or experimental treatment.

Prior Auth Contacts

Lines of Business	Contact Numbers	Provider Portal Websites
• IFP Ambetter HMO	Fax: 844-694-9165 Phone: 888-926-2164 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• IFP Ambetter PPO	Fax: 844-694-9165 Phone: 844-463-8188 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Employer Group HMO, Point of Service (POS), PPO	Fax: 844-694-9165 Phone: 800-641-7761 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Health Net Medi-Cal • CalViva Health • Community Health Plan of Imperial Valley	Fax: 800-743-1655 • Health Net: 800-675-6110 • CalViva Health: 888-893-1569 • CHPIV: 833-236-4141 Transplant fax: 833-769-1141	provider.healthnetcalifornia.com

Lines of Business	Contact Numbers	Provider Portal Websites
• Medicare (Individual and Employer Group) and Special Needs Plan (SNP)	Fax: 844-501-5713 Phone: 800-929-9224 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com
• Medicare Supplement	Fax: 844-501-5713 Phone: 800-641-7761 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com

Mailing Address

Attention: Prior Authorization Department.

21281 Burbank Blvd.

Woodland Hills, CA 91367

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Program Accreditation Department

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

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The Health Net Program Accreditation Department supports and promotes activities to assess and monitor organization-wide and provider compliance with regulatory and oversight bodies, including the California Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the California Managed Risk Medical Insurance Board (MRMIB). The department is also responsible for preparation and implementation of any identified actions based on the findings of DMHC, NCQA and CMS audits.

The Program Accreditation Department collects, reviews and assesses various required submissions from delegated participating physician groups (PPGs), including financial statements and utilization management reports.

Address to submit expedited organization determination (EOD), Notice of Medicare Non-Coverage (NOMNC) tracking logs, utilization management and financial reports:

Program Accreditation Department Compliance Analyst
21281 Burbank Blvd.



Woodland Hills, CA 91367

818-676-6704

Provider Oversight efax: 877-890-4105

UMQIMR@healthnet.com

Health Net Provider Services Center

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

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The Health Net Provider Services Center is available to physicians, participating physician groups (PPGs), hospitals, and other providers, and features live customer service representatives, an interactive voice response (IVR) system and the provider portal websites. Customer service representatives are available via telephone and online during business hours (Monday through Friday, 8 a.m. to 6 p.m. PT). Services provided include the following:

- Member eligibility and effective dates information.
- Health Net's prescription drug program information.
- Claims status information.
- Instructions on how to submit disputes and appeals.
- Instructions on how to submit a complaint regarding the provision of care by a provider or express concerns about provider office staff.
- Instructions on how to request the removal of members for disciplinary actions.
- Information about the provider portal websites.

IVR for Employer Group HMO and PPO members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member eligibility and claim information without waiting to speak with a Provider Services Center representative. For employer group HMO and PPO members, providers may contact 800-641-7761. The IVR includes:

- Current and past eligibility status.
- Benefits information.
- Single or multiple claims status.
- Claims submission addresses.
- Automated fax back of member eligibility and claim status information.

IVR for Covered California and Individual & Family Plans (IFP) members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member information. The following IVRs are available for Covered California and IFP members, which include Ambetter HMO and PPO Individuals and Families. Providers may verify or check eligibility status by member name and plan, claims status and copayment information.

IFP IVR Phone Numbers

If...	Then contact Health Net at...	And...
Covered California appears on the member identification (ID) card	888-926-2164 for Covered California Health Net members	Follow the prompts
Covered California does not appear on the member (ID) card	877-857-0701 for Health Net IFP members	Follow the prompts

Provider Services Center Contact Information

Line of Business	Phone Number	Provider Portal Website
Health Net Employer Group HMO, POS, and PPO	800-641-7761	provider.healthnetcalifornia.com
Ambetter from Health Net HMO Individual & Family Plans	888-926-2164	provider.healthnetcalifornia.com
Ambetter from Health Net PPO Individual & Family Plans	844-463-8188	provider.healthnetcalifornia.com

Claims Address

Health Net Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Email Address

provider_services@healthnet.com

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Quality Improvement Department

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

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Contact Health Net's Quality Improvement Department for questions regarding quality improvement projects (QIPs).

For commercial providers email:
cqi_dsm@healthnet.com

For Medicare providers email:
cqi_medicare@healthnet.com

Health Net's Regional Medical Directors

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

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To provide better service to participating physician groups (PPGs), hospitals, employer groups, and members, Health Net's regional medical directors are located in the Irvine, Oakland, Rancho Cordova, San Diego, Woodland Hills, and other regional offices. Health Net's regional medical directors are directly responsible for any clinical matters related to Health Net policies and procedures. They also serve as professional consultants to the PPGs and hospitals.

Health Net's regional medical directors work closely with PPGs and hospitals to monitor, manage and achieve greater efficiency in the following areas:

- Utilization management (UM), including care management
- Quality management
- Pharmaceutical management
- Case review or member complaints relating to quality of care and access
- Introduction of new products

Health Net Third-Party Liability Department

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



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Medi-Cal

Providers must notify Health Net or the participating physician group (PPG) in writing of all potential and confirmed third-party tort liability cases involving a Health Net Medi-Cal member. Notify Health Net if a provider receives any subpoenas from attorneys, insurers or beneficiaries for copies of bills. Supply Health Net with copies of the request and copies of documents released as a result of the request, and provide the name, address and telephone number of the requesting party. The notification must be submitted via email to or mail notifications to:

Health Net TPL Recovery TPL Department Mailstop: CA-4191-04-108 4191 East Commerce Way Sacramento, CA 95834

Health Net Transfer/Termination Request Unit

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

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Participating physician groups (PPGs) considering the termination of a Health Net member must submit a Transfer/Termination (T/T) Incident Report to the Health Net Transfer/Termination Request Unit.

HMO

T/T Requests
P.O. Box 10348
Van Nuys, CA 91410
Fax: 877-831-6019

Medicare Advantage HMO

T/T Requests

Medicare Services:
Health Net Appeals and Grievances Department
P.O. Box 10344
Van Nuys, CA 91410-0344
Fax: 877-713-6189

Health Net Transplant Care Manager

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

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Submit transplant information to Health Net. Health Net reviews the request and may advise the participating physician group (PPG) or provider to refer the member to a transplant performance center for evaluation. Health Net's designated transplant performance centers are Medicare-certified. On completion of any evaluation, the transplant performance center must fax the evaluation directly to the Health Net transplant care manager.
888-732-2730
Fax: 866-292-5294

Health Net Transportation Vendors

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

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- Medi-Cal: Modivcare – Members can call Where's My Ride? at 855-253-6863, TTY: 711.
- Medicare: Medical Transportation Management (MTM) Health – Medicare members can call 844-515-6876.

Health Net Utilization Management Department

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

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Health Net's Utilization Management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are the elements of the UM process.

Health Net Utilization Management Department
PO Box 10198
Van Nuys, CA 91410

Health Net Wellness and Prevention Department

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

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Contact the Health Net Wellness and Prevention Department at:

916-935-1263

Hearing Care Solutions

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

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866-344-7756
Monday through Friday
5 a.m.-5 p.m. PT

For more information, visit the Hearing Care Solutions website.

Hearing Healthcare Providers

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

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Hearing Healthcare Providers (HHP)

www.hhpca.org

HNI Corporate Address

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



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If a participating physician group (PPG) needs to request a change to the information currently in their Provider Participation Agreement (PPA), the request must be made in writing and sent to:

Health Net of California, Inc.
Attention: Vice President, Provider Contracting/Provider Network Management
21281 Burbank Blvd
Woodland Hills, CA 91367

Hoveround Inc

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

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Provider of custom rehabilitation equipment services.

800-701-5781

In-Home Operations

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

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Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment, and those at risk of life-threatening occurrences, requires close coordination between Health Net and the Home and Community-Based Services (HCBS) Waiver program administered by In-Home Operations (IHO). This program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met by providing in-home care. 916-552-9105 in Northern California
213-897-6774 in Southern California
email: IHOwaiver@dhcs.ca.gov

J&B Medical Supply Company Inc

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

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J&B Medical Supply Company, Inc. Address: 50496 W. Pontiac Trail, Wixom, MI 48393-2088 Phone: 800-737-0045
Fax: 800-737-0012 Website: www.jandbmedicalinsurance.com

Kick It California

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

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800-300-8086 (English)

800-600-8191 (Spanish)

kickitca.org

LabCorp

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

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To find a LabCorp center near you or request a pick-up, visit www.LabCorp.com or call 800-244-9698.

Linkia LLC

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

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Linkia, LLC is Health Net's preferred provider for orthotics and prosthetics.

877-754-6542

Livante (California Quality Improvement Organization (QIO)

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

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Livante
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolise Junction, MD 20701

Phone: 877-588-1123 or TTY: 855-887-6668
Appeals fax: 855-694-2929
All other reviews fax: 844-420-6672

Los Angeles Department Of Public Social Services

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

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Providers may call the Los Angeles Department of Public Social Services (DPSS) for assistance with the In-Home Supportive Services (IHSS) program.

The IHSS program provides services to seniors and persons with disabilities allowing them to remain safely in their homes.

888-944-4477 213-744-4477

Mahmee

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

Mahmee offers virtual doula services via the Mahmee mobile app that is designed to better connect new moms with health care and support. Mahmee can be contacted at the number listed below:

818-431-1118

Monday through Friday from 6 a.m. to 8 p.m. PT.

Saturday and Sunday from 8 a.m. to 6 p.m. PT.

Managed Care Ombudsman

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

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The Department of Health Care Services (DHCS) Managed Care Ombudsman investigates and attempts to resolve complaints about managed care plans that members have been unable to resolve through their health plans. 888-452-8609

March Vision Care

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

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Health Net members assigned to Molina Healthcare may contact March Vision Care to locate a participating optometrist and optician from whom to order and receive lenses and frames.

888-493-4070

Matria Health Care Inc

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

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Matria Health Care, Inc. provides home health and infusion services to high-risk obstetric members.

800-289-7744

Medical Board Of California

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

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A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to members. For a no-cost brochure, contact the Medical Board of California, Breast Cancer Treatment Options. Breast Cancer Treatment Options 1426 Howe Avenue, Suite #54 Sacramento, CA 95825 Fax: 916-263-2479

Medical Transportation Management (MTM) Health

Non-emergency standard transportation services are arranged through Medical Transportation Management (MTM) Health.

844-515-6876

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

Scheduling Non-Emergency Standard Transportation Services Through MTM Health

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

To assist Exclusively Aligned Enrollment (EAE) D-SNP members who need a higher mode of transportation (e.g. a wheelchair van), providers must complete a Physician Certification Statement (PCS) form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF)) to help members get transportation services through their Medi-Cal plan.

Submit the completed form to the Health Net Care Ride Unit to help members get authorizations for transportation.

MTM Health Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Routine transportation requests	Requires a 72-hour notification
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service.

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance and hospital discharges	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Toll-free phone numbers	Reservations: 844-515-6876

Medi-Cal Provider Contested Claims

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

Address for provider contested claims:

Health Net Medi-Cal Contested Claims Department PO Box 989736 West Sacramento, CA 95798

OR

CalViva Health Contested Claims Department PO Box 989736 West Sacramento, CA 95798

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Medi-Cal Rx CSC

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

Medi-Cal Rx

Phone: 800-977-2273 Fax 800-869-4325

Appeals
Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 730 Rancho Cordova, CA, 95741-0730

Prior authorization
Medi-Cal Rx Customer Service Center Attn: PA Request PO Box 730 Sacramento, CA 95741-0730 Phone: 800-977-2273

Medicare Appeals Council

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

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Health Net Medicare Advantage (MA) and MA members may request that the Medicare Appeals Council (MAC) review an administrative law judge (ALJ) decision. The review request must be made within 60 days from the date Health Net receives the ALJ hearing decision or dismissal. The request for appeal may be submitted directly to the MAC.

Department of Health and Human Services
Department Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

Member Rights Information

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

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This insert must be customized with the health plan and/or participating physician group (PPG)-specific phone number and applicable couty-specific phone number for the applicable legal services office.

Legal Services Offices for Assistance for Medi-Cal Managed Care Enrollees

COUNTY	LEGAL SERVICES OFFICE
Fresno	Central California Legal Services - 800-675-8001
Kern	Greater Bakersfield Legal Aid - 661-321-3982
Kings	Central California Legal Services - 800-675-8001
Los Angeles	Neighborhood Legal Services - 800-896-3203
Madera	Central California Legal Services - 800-675-8001
Orange	Legal Aid Society of Orange County - 800-834-5001

COUNTY	LEGAL SERVICES OFFICE
Riverside	Inland Counties Legal Services Indio Office - 800-226-4257 Riverside Office - 888-455-4257
Sacramento	Legal Services of Northern California - 888-354-4474
San Bernardino	Inland Counties Legal Services San Bernardino - 800-677-4257 Rancho Cucamonga - 800-977-4257
San Joaquin	Legal Services of Northern California - 888-354-4474
San Diego	Legal Aid Society of San Diego - 877-734-3258
Stanislaus	Central California Legal Assistance - 800-675-8001
Tulare	Central California Legal Services, Visalia Office - 800-350-3654

MHN Customer Service Department

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

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If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or his or her staff may contact the MHN Customer Service Department for a referral to an MHN provider. Customer service specialists may also assist with member eligibility, benefits and general questions about MHN.

888-935-5966

Providers treating CalViva Health members: 888-327-0010

MiniMed Distribution Corp Inc

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

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MiniMed Distribution Corp, Inc. provides insulin pumps and supplies to members with diabetes.

800-795-0618
Fax: 800-611-1716

Modivcare

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

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HMO

Non-emergency transportation services are arranged through Modivcare™ 24 hours a day, 7 days a week.

For HMO:

866-842-0675
Fax: 800-762-1777

HMO

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week

Medi-Cal

Refer to the table below to arrange for transportation services through Modivcare. Modivcare uses language-line interpreter services for all interpretation needs during reservations.

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Standard days and hours of customer service center operation for routine reservations.	Monday through Friday, 7 a.m. to 7 p.m. Pacific time.
Weekend and holiday schedule	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas
Routine transportation requests	- Rideshare curb-to-curb in “real time”. (For avoidance of doubt, “real time” is defined as within 1 hour of member request.) - Non-rideshare curb-to-curb 24 hours in advance (sedan, taxi) - 48-hour notice for any mode of transportation higher than sedan (wheelchair [including ambulatory door-to-door], stretcher, non-emergent ambulance)
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for the same day of service for hospital discharges and urgent treatment types. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance (Where's my Ride? line) and hospital discharges	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week

Modivcare Contact Information

FORM OF CONTACT	CONTACT INFORMATION
Toll-free telephone numbers	**Non-Emergency Medical Transportation (NEMT) services: Submit a Physician Certification Statement (PCS) form to the Health Net Care Ride Unit to obtain authorization before contacting Modivcare for scheduling.** Reservations and ride assistance (Where's My Ride? line) for Medi-Cal members: 855-253-6863 Ride assistance (Where's My Ride? line) for CalViva Health members: 855-253-6864 Ride assistance (Where's My Ride? line) for CHPIV members: 855-251-7097 Hearing impaired (TTY) line: 866-288-3133 For providers: Facility line: 866-529-2128 Facility fax: 877-601-0535
Website	Modivcare.com Providers may use the Modivcare website to schedule only routine transports with an advance notice of 5 business days. Print an enrollment form from the Modivcare website to sign up for this HIPAA-compliant service and return it by fax to 877-601-0535.

Molina Behavioral Health Services

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

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Behavioral Health Services assists providers with mental health services for Molina members.

1-888-665-4621
Fax: 1-866-472-0596

Molina Claims Department

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

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Submit written correspondence or claims, tracers, appeals, or adjustments to the Molina Healthcare Claims Department.

Molina Healthcare Claims PO Box 22702 Long Beach, CA 90801 1-888-665-4621, press 1 for provider

Molina Credentialing And Facility Site Review Department

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

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The Molina Healthcare Credentialing Department verifies all information about each Molina provider and evaluates the applicant's qualifications to be credentialed or recredentialed. Recredentialing of providers is conducted at least every three years. Credentialing: 1-800-526-8196 ext. 120117
Fax: 1-888-665-4629

Facility Site Review 1-800-526-8196 ext. 120118
Fax: (562) 499-6185

Molina Encounter Department

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

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The Molina Encounter Department handles all claims for capitated services.

P.O. Box 22807 Long Beach, CA 90801 MHCEncounterDepartment@MolinaHealthCare.com

Molina Healthcare Education Department

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

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The Molina Healthcare Education Department improves the health outcomes of Medi-Cal members through member and provider education and facilitating provider access to member education resources and information.

1-866-472-9483

Molina Healthcare Provider Resolution Department

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

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The Molina Healthcare Provider Resolution Department handles written inquiries from providers regarding claim disputes. Written inquiries should be sent to the following address.

Molina Healthcare Attn: Provider Dispute Unit PO Box 22722 Long Beach, CA 90801 Fax: (562) 499-0633

Molina Interactive Voice Response

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

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Contact the Molina Interactive Voice Response system if a member arrives at a primary care physician (PCP) office to receive care and does not appear on the current month's eligibility listing. 1-800-357-0172

Molina Member Services

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

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Molina Healthcare offers telephonic services via telephone. 1-888-665-4621

Molina Nurse Advice Line

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

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Molina&s nurse advice line is staffed 24 hours a day, seven days a week by highly trained nurses for member assistance and referrals. 1-888-275-8750 (English)
1-866-648-3537 (Spanish)

Molina Pharmacy Department

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

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The Molina Healthcare Pharmacy Authorization Desk is responsible for Molina's medication prior authorization requests.

1-888-665-4621, press 1 for provider
Fax: 1-866-508-6445

Molina PM160 INF Forms

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

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Send completed PM160 Information Only (INF) forms to Molina Healthcare via the fax below. (562) 435-3666, ext. 127350
Fax: (562) 499-6193

Molina Provider Services Department

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

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For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. The Molina Healthcare Provider Services Department is the provider liaison to the health plan's administrative programs. This department handles telephone and written inquiries from providers regarding contracting, capitation verification, scheduling of in-service training, site audit status, and credentialing information.

200 Oceangate, Ste. 100 Long Beach, CA 90802 1-855-322-4075
Fax: 1-855-278-0312 www.molinahealthcare.com

Molina Post Stabilization

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

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Molina Post Stabilization: Post stabilization calls from ERs - 844-966-5462

Fax: 1-877-665-4625 Attn: EDSU

Molina Quality Improvement Department

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

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The Molina Quality Improvement Department reviews member medical records, population-based studies on preventive care, clinical practice guidelines, focused studies, member and provider satisfaction studies, complaints and grievances, and monitors continuing quality improvement. 1-800-526-8196, ext. 126137
Fax: (562) 499-6185

Molina Utilization Management Department

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

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The Molina Healthcare Utilization Management Department handles referrals and prior authorization requests, conducts concurrent review on inpatient cases, and coordinates care for members under the case management program, including California Children's Services (CCS).

Outpatient and urgent referral requests: 1-800-526-8196, option3, then option 4

Inpatient referral requests: 1-800-526-8196, option3, then option 4

CCS referral requests: 1-888-562-5442, ext. 126586

Case management referral requests: 1-800-526-8196, ext. 127604
Fax: (562) 499-6105

Outpatient and prior authorization requests: Fax: 1-800-811-4804

Notification of inpatient admissions: Fax: 1-866-553-9262

Notification of concurrent review: Fax: 1-866-553-9263

Multipurpose Senior Services

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

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The Multipurpose Senior Services Program (MSSP) Waiver Program assists frail members ages 65 and older in remaining safe in their homes. The program is administered by the Department of Aging and provides a cost-effective alternative to institutionalization while assisting seniors in maintaining important ties to family, friends and the community. A Health Net member who meets the criteria for MSSP services and is approved and accepted into the waiver program is disenrolled from Health Net and becomes eligible for the Medi-Cal fee-for-service (FFS) program.

Amador, Calaveras, Tuolumne

Area 12 Agency on Aging
19074 Standard Road Sonora, CA 95370 209-532-6272
Fax: 209-532-6501

Fresno, Madera

Fresno and Madera Agency on Aging 3837 N. Clark Street Fresno, CA 93726 (559) 453-4405

Imperial

Imperial County Work Training Center, Inc. 210 Wake Avenue El Centro, CA 92243 760-352-6181
Fax: 760-352-6332

Inyo, Mono

Eastern Sierra Area Agency on Aging
1360 North Main Street, Suite 201 Bishop, CA 93514-2709 760-873-3305
Fax: 760-878-0266

Kings, Tulare

Kings and Tulare Area Agency on Aging 5957 S. Mooney Boulevard Visalia, CA 93277 (559) 737-4660
(800) 321-2462

San Joaquin

San Joaquin County Human Services Agency - Aging & Community Services Bureau 102 S. San Joaquin Street Stockton, CA 95202 (209) 468-1104
Fax (209) 932-2613

Stanislaus



Stanislaus County Community Services Agency 251 East Hackett Road Modesto, CA 95353 (209) 558-2346
Fax: (209) 558-2681

National Seating And Mobility

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

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Provider of custom rehabilitation equipment services.

800-404-6676

Nurse Advice Line

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

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HMO and PPO

Health Net's Nurse Advice Line is a telephonic support program that empowers members to better manage their health. The Nurse Advice Line offers support for members coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained registered nurses (health information managers) are available 24 hours a day, seven days a week.

The Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Nurses provide one-on-one consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the nurse advice line by calling the member services number on the back of their identification (ID) card.

The Nurse Advice Line is available to physicians to discuss concerns or make referrals at 800-893-5597; select the physician/provider options.

Medicare Advantage HMO

Contact the Nurse Advice Line at 800-893-5597

Peer-to-Peer Review Request Line

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To request a peer-to-peer review, call the Peer-to-Peer Review Request Line at: 833-236-9715. Be sure to have the following information available:

- Member name
- Member date of birth
- Case number
- Medical director name
- Name of the nurse who worked the case
- Member identification number

If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Pharmacy Services

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

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HMO and PPO

Providers must contact Pharmacy Services and complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) to request prior authorization for certain prescription medications before medications are dispensed.

Prior authorization type	Fax	Phone	Mail
Pharmacy and self-injectable requests	800-314-6223	800-548-5524 (Option 2)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Physician-administered medications	800-314-6223	800-867-6564 (Option 2)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Medi-Cal

Providers must contact Pharmacy Services and complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF)) to request prior authorization for certain prescription medications before medications are dispensed. Pharmacy Services is responsible for review of requests for medical benefit medication prior authorization for Health Net Medi-Cal members.

Prior authorization type	Fax	Phone	Mail
Pharmacy and self-injectable medications	800-869-4325	800-977-2273 (Medi-Cal Rx)	N/A
Physician-administered medication requests	833-953-3436	800-867-6564 (Option 2)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Medicare Advantage HMO

Providers can submit prior authorization electronically through CoverMyMeds (preferred), submit the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) or contact Pharmacy Services to request prior authorization for certain prescription medications.

Contact	Fax	Phone	Mail

Pharmacy and self-injectable medications and physician-administered medications	800-977-8226	800-867-6564 (Option 1)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Premier Eye Care

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

Premier Eye Care

833-883-2339

Monday – Friday, 8 a.m. – 8 p.m. Pacific time

Email: info@premiereyecare.net

Provider Disputes and Appeals - Commercial

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

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Address for provider disputes and appeals:
Health Net Commercial Provider Disputes
PO Box 9040
Farmington, MO 63640-9040

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Provider Network Management Department

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

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The Provider Network Management (PNM) Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

HMO, Medicare Advantage HMO, Medicare Supplement, and PPO

If you need additional information, contact the Provider Services Department (HMO, PPO, and Medicare Advantage HMO, and Medicare Supplement) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For hospitals and PPGs, if you need further assistance you may contact your regional provider network manager or provider network administrator.

Medi-Cal

If you need additional information, contact the Provider Services Department (Health Net, CalViva Health or Community Health Plan of Imperial Valley) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Provider Network Management, Access and Availability Team

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

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Email: Provider Network Management, Access and Availability Team for more information.

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Provider Relations Department

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

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The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.

Email: The Provider Relations Department

Pumping Essentials

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

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Health Net's preferred breast pump provider.

866-688-4203

Quest Diagnostics

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

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For information about Quest Diagnostics laboratory testing solutions and services or to set up an account, call 866-697-8378.

To locate a Quest Diagnostics Patient Service Center (PSC), or schedule a PSC appointment for a Health Net member, log on to the Quest Diagnostics website or call 888-277-8772.

Regional Centers

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

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Regional centers are private, non-profit corporations under contract with the California Department of Developmental Services (DDS). Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidence of developmental disabilities. Below are the regional centers as indicated for each county:

Amador, Calaveras and Tuolumne

Valley Mountain Regional Center
702 North Aurora Street Stockton, CA 95202 209-473-0951
Fax: 209-473-0256

Fresno, Kings, Madera, and Tulare

Central Valley Regional Center 4615 North Marty Ave. Fresno, CA 93722 559-276-4300
Fax: (559) 276-4360

Imperial

San Diego Regional Center 4355 Ruffin Road, Suite 200 San Diego, CA 92123-1648 858-576-2996
Fax: 858-576-2873

Inyo, Kern and Mono

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93308 661-327-8531
Fax: 661-324-5060

Kern

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93305 661-327-8531

Los Angeles

Eastern Los Angeles Regional Center 1000 South Fremont Ave., PO Box 7916, Alhambra, CA 91802-4700 626-299-4700

Frank D. Lanterman Regional Center 3303 Wilshire Blvd., Ste. 700, Los Angeles, CA 90010-2197 213-383-1300

Harbor Regional Center 21231 Hawthorne Blvd., Torrance, CA 90503 310-540-1711

North Los Angeles Regional Center 15400 Sherman Way, Ste. 170, Van Nuys, CA 91406 818-778-1900

San Gabriel/Pomona Regional Center 75 Rancho Camino Dr., Pomona, CA 91766 909-620-7722

South Central Los Angeles Regional Center 650 W. Adams Blvd., Ste. 200, Los Angeles, CA 90007 213-744-7000

Westside Regional Center 5901 Green Valley Circle, Ste. 320, Culver City, CA 90230-1024 310-258-4000

Sacramento

Alta California Regional Center 2241 Harvard St., Sacramento, CA 95815 916-978-6400
Fax: (916) 929-1036

San Diego

San Diego Regional Center for the Developmentally Disabled 4355 Ruffin Rd., Ste. 200, San Diego, CA 92123-1648 858-576-2931

San Joaquin and Stanislaus

Valley Mountain Regional Center 702 N. Aurora St., Stockton, CA 95202 209-473-0951
Fax: (209) 473-0256

Reinsurance Claims Unit

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

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Insured service claims should be sent to:

Reinsurance Claims Unit/LNR - C3
Attn: Mail Code - CA-100-03-02
21281 Burbank Blvd.
Woodland Hills, CA 91367

River City Medical Group

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

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River City Medical Group (RCMG) members may contact RCMG to locate a participating optometrist and optician from whom to order and receive lenses and frames.

800-928-1201

Roche

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

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Provider of insulin pumps and supplies to members with diabetes.

800-280-7801

San Diego County Aging and Independence Services

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

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The San Diego County Aging and Independence Services (AIS) provides services to seniors and persons with disabilities and their family members allowing them to remain safely in their homes.

Providers can call the San Diego County AIS for assistance with In-Home Supportive Services (IHSS) or the Multipurpose Senior Services Program (MSSP).

800-510-2020

San Francisco Medi-Cal Field Office

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

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Except for kidney transplants, major organ transplant authorization requests for Medi-Cal members age 21 and over must be sent to the San Francisco Medi-Cal Field Office. 575 Market Street, Suite 400 San Francisco, Ca 94105 415-904-9600

Mailing address: P.O. Box 193704 San Francisco, CA 94119

SilverSneakers Program

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

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Health Net contracts with American Specialty Health Fitness, Inc. to administer and arrange a fitness service for Health Net members in accordance with the member's applicable benefits plan. Refer members to the Silver&Fit® website for more information.

Smiths Medical Inc

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

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Provider of insulin pumps and supplies.

800-826-9703

Solutran

Multi-Benefit Spendables Card

Wellcare By Health Net Dual Special Needs Plan (D-SNP) offer members extra benefits at no cost. Included in the plan, members have an over-the-counter (OTC) benefit where they will receive a fixed dollar monthly allowance amount preloaded into their Wellcare Spendables Card. The monthly allowance rolls over to the following month if unused and expires at the end of the plan year.

Members may use the Wellcare Spendables Card OTC dollars to purchase everyday items like bandages, pain relievers, cold remedies, toothpaste and much more. The card can be used on any combination of the following:

- Over-the-counter items such as cold medicine, first aid supplies, and vitamins.
- Buy groceries.
- Pay for utilities such as electric, gas, trash, water, internet, cable, and phone service.
- Help with the cost of rent for their home.
- Pay for gas at the pump (cannot be used to pay in person at the cash register).

Note:

- Any unused funds will roll over to the next month and will expire at the end of the year.
- The card cannot be used to set up automated, recurring payments.
- The care can only be used up to the available allowance amount.
- The card is similar to a debit card. Members can use their card to pay for eligible items and services at participating retail location or order online that accept Visa.

For more information about this benefit, members may contact Solutran.

855-744-8550
April-September
Monday through Friday
5 a.m.-8 p.m. Pacific time (PT)

October-March
7 days a week
5 a.m.-8 p.m. PT

For more information, visit secure member website.

Sonus

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

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888-383-4521

SONUS

Special Supplemental Nutrition Program For WIC

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

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The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition education and specific foods for women, infants and children from families with low incomes. WIC is temporary and provides supplemental food and nutrition education for a limited time during critical periods of growth and development.

Amador



430 Sutter Hill Rd. Sutter Creek, CA 95685 209-223-7685

Calaveras

209-223-7685

Fresno

Special Supplemental Nutrition Program

Location	Phone Number
Fresno Economic Opportunity Commission	559-263-1150
Huron WIC Clinic	559-945-5090
Kerman WIC Clinic	559-846-6681
Mendota	888-638-7177
Orange Grove	888-638-7177
Parlier WIC Clinic	888-638-7177
Reedley WIC Clinic	888-638-7177
Sanger WIC Clinic	888-638-7177
Selma WIC Clinic	888-638-7177

Imperial

2600 Thomas Dr. El Centro, CA 92243 877-686-5468
Fax: 760-353-2555

Inyo

760-872-1885

health net

Kern

Community Action Partnership 500 E. California Bakersfield, CA 93307 661-327-3074
Fax: (661) 327-2833

Clinica Sierra Vista - WIC Administrative Office 1430 Truxtun Avenue, Suite 300 Bakersfield, CA 93301
661-862-5422
661-326-6490
800-707-4401
Fax: (661) 322-1418

Kings

Special Supplemental Nutrition Program

Location	Phone Number
Hanford, Lemoore, Avenal, Corcoran, Kettleman	559-582-0180

Los Angeles

Special Supplemental Nutrition Program

Location	Phone Number
Antelope Valley Hospital	661-949-5805
Harbor - UCLA Research and Education Institute	310-661-3080
Long Beach	562-570-4242
Northeast Valley Health	818-361-7541 800-942-9675
Orange County Health Care	714-834-8333
Pasadena	626-744-6520
Public Health Foundation Enterprises	888-942-2229 626-856-6600
Watts Health Foundation	323-568-3070

Madera

Special Supplemental Nutrition Program

Location	Phone Number
Madera	559-675-7623
Oakhurst	559-658-7456
Chowchilla	559-201-5000

Mono

760-924-4610

Sacramento

Community Resource Project WIC Program 915 Broadway Sacramento, CA 95818 916-326-5830

Sacramento County Department of Health and Human Services 2251 Florin Road, Suite 100 Sacramento, CA 95822 916-427-5500

San Diego

Special Supplemental Nutrition Program

Location	Telephone Number
American Red Cross WIC	800-500-6411
North County Health Services	Appointment line: 888-477-6333 or 760-471-2743
San Diego State University Foundation	Client Call Center: 888-999-6897
San Ysidro Health Center	Appointment line: 619-426-7966

San Joaquin

San Joaquin County Public Health Services 1145 N Hunter Street Stockton, CA 95202 209-468-3281
Fax 209-468-8573

Stanislaus

Stanislaus County Health Services WIC Program 401 Building E. Paradise Road Modesto, CA 95351
209-558-7377
Fax: 209-558-8318

Tulare

New WIC appointments and client line: 800-360-8840
559-685-2521

Porterville Clinic 1055 West Henderson, Suite 5 Porterville, CA 93257 559-788-1323

Tuolumne

209-533-7434

State Hearing Division

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

Members can ask for a State Hearing in the following ways:

- Online
- By phone:
  - 800-743-8525.
  - TTY/TDD 800-952-8349.
- In writing:
  - Members should fill out a State Hearing form or write a letter. Send it by mail or fax to: Mail: California Department of Social Services

State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430 Fax:
916-309-3487 or toll-free at 833-281-0903

Teladoc Health

Wellcare By Health Net (Health Net) has partnered with Teladoc Health™ (Teladoc) to give members access to telehealth care at no additional cost. Telehealth, or virtual care, allows members to interact with a doctor, nurse or therapist by phone or video without leaving the comfort and safety of their home for many healthcare services.

Teladoc Health offers convenient telehealth services for members. Through Teladoc Health, members can get confidential access to virtual visits with quality doctors and behavioral health providers. Members can schedule a visit with one of Teladoc Health's U.S. board-certified doctors and behavioral health providers, they can be diagnosed, treated and prescribed medication if medically necessary.

Members can use their telehealth benefit for:

- Non-emergency care from in-network providers using their home phone, laptop, table, or smartphone to connect for a video call.
- Speak to a Nurse 24/7: Get answers to health questions and find out if they need to see a doctor or urgent care center.
- Book a phone or video appointment.

Telehealth services with in-network providers work just like face-to-face in office appointments. Telehealth visits do not require a prior authorization. Plan copays, coinsurance and deductible costs may apply. Members may refer to their plan Summary of Benefits for coverage.

To preregister for Teladoc services, visit Teladoc Health.

800-835-2362 Available 24 hours a day, 7 days a week

Tuberculosis Control Program

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

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Tuberculosis (TB) screening and treatment services for Health Net Medi-Cal members are covered by Health Net under the Department of Health Services (DHS) contract. Health Net collaborates with local health departments (LHDs) to control the spread of TB and to help members get TB treatment. Health Net coordinates with LHDs to establish effective coordination of care. Early diagnosis, immediate reporting to LHDs, and effective TB treatment are critical to interrupting continued transmission of TB. Physicians must report known or suspected cases to the LHD TB Control program office within one day of identification.

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3434
Fax: 559-445-3598



Kern

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

Kings

Kings County Department of Public Health Communicable Disease Services 1400 West Lacey Boulevard Hanford, CA 93230 559- 584-1401 ext. 2741

Madera

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

Sacramento

Sacramento County DHHS, Chest Clinic Paul F Hom Primary Care Center 4600 Broadway, Room 1300 Sacramento, CA 95820 916-874-9823
Fax: 916-874-9442

San Diego

Tuberculosis (TB) Control Program 619-540-0194

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3828
Fax 209-468-8222

Stanislaus

Stanislaus County Health Services Agency 209-558-7700
Fax: 209-558-5014

Tulare



Tulare County Department of Health Services 559-685-2275
Fax: 559-685-4786

Transitional Care Services

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

The Transitional Care Services (TCS) program ensures a smooth transition from one setting to another and reduces re-hospitalization risks and other potentially adverse events.

Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post-discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner.

Knowledge of internal and external processes surrounding the inpatient and post-discharge stay is essential in navigating the health care continuum and addressing barriers to post-discharge success for the member.

Members can call the Transitional Care Services toll free line anytime during their inpatient stay or after their discharge to request TCS support 866-801-6294.

Providers are encouraged to refer members while inpatient or recently discharged from a hospital within the past 10 days to the Transitional Care Services program. Providers are still responsible for ECM and CS referrals/coordination as appropriate and required by DHCS.

If the member is beyond the 10 days post discharge, please refer to the Complex Case Management Program.

Transplant Team

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

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Transplant Team

Fax: 833-769-1141

TurningPoint Healthcare Solutions, LLC

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

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TurningPoint Healthcare Solutions, LLC is responsible for prior authorization for:

- Certain inpatient and outpatient musculoskeletal surgical procedures for HMO, POS, HSP, EPO, PPO (Commercial) and Medi-Cal lines of business.
- Cardiovascular and ear, nose and throat (ENT) for Commercial lines of business.

TurningPoint Contacts

Phone: 855-332-5898

Fax: 949-774-2254

Email: centenecaum@turningpoint-healthcare.com

Website: MyTurningPoint

Training: Email provider support or contact TurningPoint by telephone at 866-422-0800

VRI

Personal Emergency Response Systems (PERS)

Medical alert systems can provide peace of mind if or when member have a medical emergency. Medicare members are covered for one personal emergency medical response (PERS) device per lifetime and the monthly fee at no additional cost. A PERS device provides peace of mind and 24/7 response to member's emergent and non-emergent needs. Prior authorization may be required.

VRI
800-860-4230, Option 2
Monday through Friday
5 a.m.-5 p.m. Pacific time

For more information, visit VRI.

Wellcare by Health Net Medicare Member Services Department

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

Health Net directs calls about coverage for Medicare members to the Health Net Medicare Member Services Department. If you have questions about Medicare services for these members, contact:

- 800-275-4737 (TTY: 711): Medicare Advantage (HMO) Plans (non-SNP)

- 800-431-9007; (TTY: 711): Medicare Advantage Dual Special Needs Plans (HMO D-SNP) and Medicare Advantage Chronic Special Needs Plans (HMO C-SNP)

Mail to:
Health Net Medicare Advantage for California
PO Box 10420
Van Nuys, CA 91410

Western Drug

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

Western Drug

Attention Celeste Melgoza Email: celeste@westerndrug.com

Fax: 818-551-9612 or 818-956-6695

Western Drug direct phone: 818-956-6691

Send a Blood Pressure Monitor Request Form (Medi-Cal, CalViva, CHPIV) to our preferred DME provider, Western Drug.

Glossary

- AIDS
- Approved Clinical Trial
- Appeal
- Certificate of Insurance (COI)
- Clean Claim
- Definition of Contracted Provider Dispute
- Complaint
- Emergency
- Emergency Services and Care (Behavioral Health)
- Evidence of Coverage (EOC)
- Facility Site Review
- Grievance
- Hospice Services
- Inquiry
- Life-Threatening Emergent (Behavioral Health)
- Investigational Services
- Medical Necessity
- Medical Waste Management Materials
- Mental health application information (Behavioral Health)
- Mental Health Digital Service (Behavioral Health)
- Non-Life Threatening Emergent (Behavioral Health)
- Non-Urgent, Pre-Service Decision (Behavioral Health)
- Medical Information
- Not Medically Necessary
- Offshore
- Opt Out Provider
- Participating Provider
- Post-Service Decision (Behavioral Health)
- Post-Stabilization Services (Behavioral Health)
- Primary Care Physician (PCP)
- Psychiatric Emergency Medical Condition
- Rape and Sexual Assault
- Residential Treatment
- Routine (Behavioral Health)
- Telehealth
- Schedule of Benefits or Summary of Benefits (SOB)
- Serious Illness
- Subcontractor
- Unclean Claim
- Urgent (Behavioral Health)
- Urgent Concurrent Review Decision (Behavioral Health)
- Urgent Decision (Behavioral Health)
- Urgent Pre-Service Decision (Behavioral Health)

Terms Glossary

This section contains general terms information for providers. Please select a term from the navigation list, or choose your line of business below.

- Medi-Cal Glossary
- Medicare Advantage Glossary
- HMO Glossary
- PPO Glossary

AIDS

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

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The definition of AIDS includes several diagnoses with and without HIV positivity. The services that are directly attributed to these specific diagnoses are paid for through special risk reinsurance. These diagnoses include:

- Candidiasis of esophagus, trachea, bronchi, or lungs
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis with diarrhea in indivduals older than one month
- Cytomegalovirus disease in organs other than liver, spleen or lymph nodes in individuals older than one month
- Kaposi's sarcoma in indivuduals younger that age 60
- Lymphoma of the brain (primary) in individuals younger than age 60
- Mycobacterium avium complex/M. Kansasii disease, disseminate
- Pneumocystis carinii pneumonia
- Progressive multifocal leukoencephalopathy
- Toxoplasmosis of the brain in individuals older than one month
- Herpes simplex virus with an ulcer lasting longer than one month or herpes simplex virus with bronchitis, pneumonia, or esophagitis in individuals older than one month

Additional diagnoses associated with AIDS require a positive HIV test in order to be covered under the special risk reinsurance pool. These diagnoses include:

- CD4 T-lymphocyte count less than 200
- Recurrent pneumonia, more than one episode within one year
- Invasive cervical cancer
- Coccidiomycosis, disseminated
- HIV encephalopathy
- Histoplasmosis, disseminated
- Isosporiasis with diarrhea more than one month

- Non-Hodgkin's lymphoma
- Tuberculosis
- Recurrent salmonella septicemia
- HIV wasting syndrome

Approved Clinical Trial

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

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Health Net covers routine patient care costs for members participating in an approved clinical trial including items and services furnished in connection with participation by members in a qualifying clinical trial. An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The United States Department of Veterans Affairs.
    - The United States Department of Defense.
    - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

Coverage of routine patient care costs is to be provided regardless of geographic location or if the treating provider or principal investigator of the qualifying clinical trial is a network provider. Coverage of routine patient care costs must be based on provider's and principal investigator's approval regarding the member's appropriateness for the qualifying clinical trial.

Authorizations for items and services furnished in connection with participation by members in a qualifying clinical trial are expedited and completed within 72 hours.

Health Net requires the submission of the Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for approval of the clinical trial. The attestation form must include the following information:

1. The member's name and client identification number;
2. The national clinical trial number;
3. A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
4. A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

Appeal

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

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Member Request for Reconsideration

A verbal or written request to reconsider a previous decision or adverse determination. Requests can be from a member, the member's participating provider or the member's representative and are categorized as: pre-service, post-service, expedited, or external review.

Certificate of Insurance (COI)

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

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The Certificate of Insurance (COI) is a document issued by Health Net Life Insurance Company to employees insured under a group insurance policy, which describes the covered services, supplies and exclusions and limitations that apply to the benefits for which the employee and their insured dependents are eligible. COIs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's COI by requesting it from the Health Net Provider Services Center. COIs apply to Health Net Life, PPO, EPO and Flex Net plans.

Clean Claim

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

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Physician Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, physician name(s), date of service (DOS), diagnosis code(s), and billed amount among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

PPG Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, participating physician group (PPG) and physician names, date of service (DOS), diagnosis code(s), and billed amount are among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

Complaint

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

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First Contact Resolution

Any verbal expression of dissatisfaction regarding quality-of-service (excluding quality-of-care) that can be resolved in an initial contact with Health Net's Member Services Department. This first contact resolution must

be to the member or participating provider's satisfaction, such that they do not ask for additional assistance or recompense.

Definition of Contracted Provider Dispute

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

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A contracted provider dispute is a provider's written notice to Health Net challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested, or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's Tax ID number or Health Net's provider ID number, provider's contact information, and:

If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Health Net to a contracted provider, the following must be provided:

- Original claim form number (located on the RA).
- A clear identification of the disputed item.
- The date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.

If the contracted provider dispute is not about a claim:

- A clear explanation of the issue and the provider's position on such issue.

If the contracted provider dispute involves an enrollee or group of enrollees:

- The name and identification number(s) of the enrollee or enrollees.
- A clear explanation of the disputed item, including the date of service.
- Provider's position on the disputeAn enrollee's written authorization for the provider to represent said enrollees.

Emergency

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

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The Department of Managed Health Care's (DMHC's) definition for an emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Per the DMHC, emergency services and care means:

1. Medical screening, examination and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the emergency medical condition, within the capability of the facility; and/or
2. An additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of the facility.

The Medicare definition of an emergency medical condition and emergency services is as follows:

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Emergency Services and Care (Behavioral Health)

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

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1. Screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists; and
2. Treatment necessary to relieve or eliminate the psychiatric emergency medical condition. The intent is to assure that enrollees who have non-medical, mental health emergencies receive proper access to and continuity of care.

Emergency Services and Care also means additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition.

Emergency Services and Care also means additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition.

Psychiatric Emergency Medical Condition means a psychiatric medical condition for which the onset is sudden and manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the afflicted person, or others, in serious jeopardy.
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part. In cases of the provision of Emergency Services and Care, the provider agrees to notify Health Net as soon as possible, but no later than 24 hours after it could be reasonably determined that the patient is an enrollee.

Evidence of Coverage (EOC)

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

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The Evidence of Coverage (EOC) is any certificate, agreement, contract, brochure or letter of entitlement issued to a member setting forth the coverage to which the member is entitled. The EOC for each HMO, HSP and POS plan contains comprehensive terms and conditions of Health Net coverage. EOCs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's EOC by requesting it from the Health Net Provider Services Center. EOCs apply to Health Net HMO, HSP and POS plans only. Language used in these documents is reflective of current laws and regulations and meets disclosure requirements applicable to health plan documents. The text included in the EOC is wholly subject to regulatory review and approval prior to use.

Facility Site Review

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

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All primary care physicians (PCPs) participating in Medi-Cal managed care are required by California statute (Title 22, CCR Section 56230) to complete an initial facility site inspection and subsequent periodic facility site inspections regardless of the status of other accreditation and/or certifications program as part of the initial credentialing process. The full scope site review includes the facility site review (FSR) and medical record review (MRR).

All PCP sites must also undergo the Physical Accessibility Review Survey (PARS). PARS is conducted for participating PCPs, high-volume specialists, ancillary providers, and hospitals. The PARS tool includes 86 criteria and highlights six specific indicators. Based on the outcome of the new PARS (Seniors and Persons with Disabilities (SPD)) evaluation, each PCP site is designated as having basic or limited access, as described below, along with the six specific accessibility indicator designations for parking, external building, interior building, restrooms, exam rooms, and medical equipment (for example, accessible weight scales and adjustable exam tables).

- Basic access - demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room, and restroom. To meet basic access requirements, all 29 critical elements must be met.
- Limited access - demonstrates facility site access for the member with a disability are missing or incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in one or more of the critical elements are encountered.

Results of the PARS assessment component of the FSR audit are made available to the Health Net Medi-Cal Member Services Department and CalViva Health Medi-Cal Member Services to assist members in selecting a PCP that can best serve the member's health care needs.

Grievance

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

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Grievance means any expression of dissatisfaction about any matter other than an adverse benefit determination (ABD), and may include, but is not limited to: the quality of care or services provided, aspects of interpersonal relationships with a provider or contractor’s employee, failure to respect a member’s rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by contractor to make an authorization decision. A complaint is the same as grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other contractor processes.

Hospice Services

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

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

For additional information refer to Criteria for Hospice Appropriateness.

Description

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

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

Hospice Consideration Request

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

Inquiry

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

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Member Question

Any verbal or written question for clarification, without an expression of dissatisfaction or request for reconsideration (such as a request for information or action by a member).

Investigational Services

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

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This definition is provided for illustrative purposes only. Consult the applicable health benefit plan contract (member's *Evidence of Coverage*) for the specific definition of *investigational or experimental.*

Investigational or experimental is used to describe a service (a medication, biological product, device, equipment, medical treatment, therapy, or procedure) that Health Net has determined is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury.

A service is considered experimental or investigational if it meets any of the following criteria:

- It is currently the subject of an active and credible evaluation (such as clinical trial or research) to determine:
  - Clinical efficacy
  - Therapeutic value of beneficial effects on health outcomes
  - Benefits beyond any established medical based alternatives

- It does not have final clearance from applicable government regulatory bodies, such as the United States Food and Drug Administration (FDA), and unrestricted market approval for use in the treatment of a specified medical condition of the condition for which authorization of the service is requested and is the subject of an active and credible evaluation.
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Life-Threatening Emergent (Behavioral Health)

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

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Referrals for service which require immediate evaluation.

Medical Necessity

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

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Definitions of Medical Necessity and Investigational Services

Health Net's has provided a clarification of terms used in its medical policies for medical necessity, investigational or experimental, and not medically necessary and not investigational. This clarification should enable participating physician groups (PPGs) to more quickly determine whether a service is considered investigational and, therefore, timely submit the request for a proposed service to Health Net for utilization management (UM) review and determination based on the terms of the provider's contract.

Commercial

Except where state or federal law or regulation requires a different definition, Health Net defines “Medically Necessary” or comparable terms in each agreement with physicians, physician groups, and physician organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition. “Medically Necessary” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of mental health or substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and members or for the convenience of the patient, treating physician, or other health care provider.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Pursuant to Insurance Code, Section 10144.52, Health Net bases any medical necessity determination or the utilization review criteria that the Plan, and any entity acting on the Plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health or substance use disorders on current generally accepted standards of mental health or substance use disorder care. All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of members diagnosed with mental health or substance use disorders shall be conducted in accordance with the requirements of Section 1374.721.

Medi-Cal

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the members' current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Behavioral Health Medical Necessity or Medically Necessary Definition

Except where state or federal law or regulation requires a different definition, the behavioral health team shall apply the following definition of medically necessary (Health & Safety Code: 1374.72 (3)(A)

A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the generally accepted standards of mental health or substance use disorder care.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health or substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health or substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the U.S. Food & Drug Administration.

Medical Necessity for Non-Specialty Mental Health Services (NSMHS):

The health plan will cover medically necessary services, which are defined by the MHP as reasonable and necessary services to protect life, prevent significant illness or significant disability, alleviate severe pain through the diagnosis and treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity (Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).

These include services to: diagnose a mental health condition and determine a treatment plan for the treatment of mental health conditions that result in mild or moderate impairment (excluding couples and family counseling for relational problems); refer adults to the county MHP for specialty mental health services when a mental health diagnosis covered by the MHP results in moderately to severely significant impairment; or refer children under age 21 to the MHP for specialty mental health services when they meet the criteria for those services (regardless of severity of impairment for beneficiaries under age 21).

Medi-Cal Specialty Mental Health Services (SMHS)

The federal Section 1915(b) Medi-Cal Waiver requires Medi-Cal members needing SMHS to access these services through MHPs. For individuals under 21 years of age and in accordance with California Welfare & Institutions Code (W&I Code) sections 14059.5 and 14184.402, a service is “medically necessary” or a “medical necessity” if the service meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the United States Code (USC).

The federal EPSDT mandate requires states to furnish all services it defines as appropriate and medically necessary services that could be covered under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state’s Medicaid State Plan.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered under the EPSDT mandate.

By contrast, for members who are 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I code section 14059.5).

Medicare Advantage

The Centers for Medicare and Medicaid Services (CMS) defines medical necessity and medically necessary services as services or supplies that: are proper and needed for the diagnosis or treatment of medical conditions, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or health care provider.

Medical Waste Management Materials

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



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The following are definitions of medical waste management materials:

Biohazard bag - A disposable red bag that is moisture-resistant and has sufficient strength to withstand ripping, tearing or bursting under normal conditions of use. A biohazard bag must be certified by the manufacturer and constructed of material of sufficient thickness strength to pass the 165 g dropped dart impact resistant test.

Biohazardous waste - Laboratory waste, including:

- medical and pathological human specimen cultures
- cultures and stocks of infectious agents
- waste from the production of bacteria, viruses or the use of spores, discarded live and attenuated vaccines, culture dishes and contaminated devices used for above
- discarded waste from specimens sent to the laboratory
- human specimens or tissues removed during surgery or autopsy, which are suspected by the attending physician or dentist of being contaminated with infectious agents

Medical waste - Biohazardous waste, sharps waste or waste generated or produced as a result of diagnosis, treatment or immunization of human beings. Medical waste may be infectious.

Sharps waste - Any device having acute rigid corners or edges or projections capable of cutting or piercing, including:

- hypodermic needles, syringes, blades, and needles
- broken glass items, pipettes and vials that are contaminated with other medical waste

Medical Information

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

“Medical information” is any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment.

“Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient’s name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

“Mental health application information” means information related to a consumer’s inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

“Mental health digital service” means a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

- Reproductive or sexual health application information – information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
- Reproductive or sexual health digital service – a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
- "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

A business entity that offers a "sexual health digital service" is now considered a "provider" under the California Medical Information Act (CMIA, 56.06)(e).

- Any business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of this part. However, this section shall not be construed to make a business specified in this subdivision a provider of health care for purposes of any law other than this part, including, but not limited to, laws that specifically incorporate by reference the definitions of this part.

Mental Health Application Information (Behavioral Health)

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

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Information related to a consumer's inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

Mental Health Digital Service (Behavioral Health)

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



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Mobile-based application or internet websites that collect mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

Non-Life Threatening Emergent (Behavioral Health)

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

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Represents a clinical risk rating assigned by a licensed clinician who has determined that a member requires services within six hours. In these cases, the clinician has determined that without services in this time frame, there is a likelihood that the member will become an imminent danger to themselves or others or become gravely disabled.

Non-Urgent, Pre-Service Decision (Behavioral Health)

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

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Any case or service that requires prior authorization by Health Net, in whole or in part, in advance of the member obtaining medical care or services that do not meet the criteria for an urgent decision.

Not Medically Necessary and Not Investigational

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

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Evaluation and clinical recommendations are assessed according to the scientific quality of the supporting evidence and rationale (such as national medical associations, independent panels or technology assessment organizations).

A service is considered not medically necessary and not investigational if it meets any of the following criteria:

- There are no studies of the service described in recently published peer-reviewed medical literature
- There are no active or ongoing credible evaluations being undertaken of the service, which has previously been considered not medically necessary
- There is conclusive evidence in published peer-reviewed medical literature that the service is not effective
- There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety or efficacy of the use of the service
- It is contraindicated

Offshore

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

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The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and American Virgin Islands). Examples of countries that meet the definition of offshore include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Opt Out Provider

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

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A provider who has opted out of Medicare has terminated their Part B contract with Medicare by submitting a valid affidavit to the local Medicare carrier. Affidavits are valid for two years. After the two-year period has expired, the provider may elect to return to Medicare or opt out again. Services received from a provider that has opted out of Medicare are not covered.

Participating Provider

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

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A facility, physician, physician organization, other health care provider, supplier, or other organization, which has met applicable credentialing and/or recredentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net, or indirectly through another entity, such as, another participating provider, to provide covered services. Health care provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Post-Service Decision (Behavioral Health)

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

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Any review for care or services that has already been received and completed but not previously reviewed and authorized.

Post-Stabilization Services (Behavioral Health)

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

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Medically necessary services that are related to an emergency medical condition, provided after a member is stabilized, and provided to maintain the stabilized condition or, under certain circumstances, to improve or resolve the member's condition.

Primary Care Physician (PCP)

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



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A doctor of medicine (MD), doctor of osteopathy (DO) or other health care professional who: (1) is duly licensed and qualified under the laws of the relevant jurisdiction to render contracted services; (2) is a participating provider and (3) meets the credentialing standards of Health Net for designation as a PCP and who provides for continuity of care and 24-hour-a-day, seven-day-a-week availability to beneficiaries.

Psychiatric Emergency Medical Condition

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

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A psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others or immediately unable to provider for, or utilize, food, shelter, or clothing, due to the mental disorder.

Rape and Sexual Assault

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

Under California law, rape and sexual assault generally involve non-consensual sexual acts. Below is a simple breakdown as derived from the California Penal Code (PC), which can be accessed in detail through the California Legislator.

- **Rape** (PC 261, 263, 263.1): Non-consensual sexual intercourse accomplished through force, threats, fraud, or when the victim is unable to give consent due to intoxication, unconsciousness, or mental incapacity.
- **Consent** (PC 261.6): A voluntary, freely given agreement to engage in sexual activity. Lack of resistance does not imply consent.
- **Sodomy and oral copulation** (PC 286, 287): Engaging in anal or oral sex without consent, using force, threats, or exploiting a victim's inability to resist.
- **Sexual acts with a child** (PC 288.7): Any sexual intercourse, sodomy, or oral copulation with a child under 10 years old is a felony.

Residential Treatment

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

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Residential treatment is available, based on medical necessity with this added benefit. Medi-Cal members seeking residential treatment are referred to their respective county Specialty Mental Health division .

A residential treatment center is defined as a 24-hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. This plan requires that all contracting residential treatment centers hold appropriate licensure by their state in order to provide residential treatment services.

This plan does not cover admission to the following residential treatment facility types as they are not considered to be medical treatment:

- Foster homes or halfway houses
- Wilderness Center training
- Therapeutic boarding schools
- Custodial care, situation or environmental change

Routine (Behavioral Health)

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

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Referrals for services requiring evaluation by a licensed mental health professional within 10 business (14 calendar) days or a psychiatrist within 15 business days.

Telehealth

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

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Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care. Telehealth facilitates patient self-management and caregiver suppot for patients and includes synchronous interactions and asynchronous store and forward transfers.

- **Originating site** - The site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward transfer originates.
- **Distant site** - The site where a health care provider who provides health care services is located while providing these services via a telecommunications system.
- **Synchronous interaction** - A real-time interaction between a patient and a health care provider located at a distant site.

- **Asynchronous store and forward transfer** - The transmission/transfer of a patient's medical information from an originating site without the patient being present to the health care provider at a distant site.

Schedule of Benefits or Summary of Benefits (SOB)

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

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The Schedule of Benefits is a brief list of benefits, with applicable copayment, coinsurance and deductible information for the member's health plan. It does not list the exclusions and limitations or other important legal and contractual terms applicable to the plan; these are described in the EOC or COI.

The Schedule of Benefits is called the Summary of Benefits for certain Medicare Advantage plans, including C-SNP and D-SNP. The Summary of Benefits has the same information as the Schedule of Benefits but in a slightly different format.

The Schedule of Benefits and Summary of Benefits are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may access members' Schedule of Benefits on the provider portal. Once you log in, select *Patients* > the applicable member from the list > *Schedule of Benefits* .

Schedule of Benefits are available for all Health Net plans (except California Medi-Cal plans)

Serious Illness

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

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Serious illness is defined as a condition that may result in death, regardless of the estimated length of the patient's remaining period of life.

Subcontractor

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

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A subcontractor is any organization with which a first-tier, downstream or related entity contracts to fulfill or help fulfill requirements in its contracts.

Note: A subcontractor means an individual or entity who has a subcontract with the plan that relates directly or indirectly to the performance of the plan's obligation under the contract with the Department of Health Care Services (DHCS).

Unclean Claim

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

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An unclean claim lacks sufficient information to pay or deny, and results in an examiner requesting information from a source outside the Medicare Advantage Organizations (MAOs), such as a participating physician group (PPG) or hospital. The following are examples of claims considered to be unclean (this list is not all inclusive):

- A claim does not have the necessary fields completed to process the claim, for example, the provider identification (ID) number.
- The claim does not have a diagnosis that is immediately identifiable as an emergency, out-of-area urgently needed service, or out-of-area renal dialysis.
- The claim lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergency care.
- A claim that appears to be fraudulent or is in a foreign language or currency.

Unclean Claim Adjudication

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), MAOs and PPGs are required to pay or deny non-clean claims within 60 calendar days of receipt.

Urgent (Behavioral Health)

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

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Referrals for service which require evaluation by a licensed mental health professional within 48 hours.

Urgent Concurrent Review Decision (Behavioral Health)

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

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Any review for treatment that has already begun.* This determination is always considered urgent, with the following exception:

1. If the request is to extend a course of treatment beyond the period of time or the number of treatments previously approved by Health Net, and the treatment involved does not meet the definition for an Urgent Decision below, default to the Non-Urgent Pre-Service category.

** For Medicare, treatment that has begun within one (1) business day can be considered Pre-Service Urgent.*

Urgent Decision (Behavioral Health)

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

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Any request with respect to which the application of the time periods for making non-urgent care determinations:

Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a subjective standard that focuses on the belief in the existence of an Emergency Medical Condition or Psychiatric Emergency Medical Condition that requires immediate medical and/or psychiatric treatment; or

In the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Urgent Pre-Service Decision (Behavioral Health)

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

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Any case or service that requires prior authorization by Health Net, in whole or in part, in advance of the member obtaining medical care or services that meet the criteria for an urgent decision listed above.

Forms and References

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

#

A

- AAP Recommendations for the Preventive Pediatric Health Care (PDF)
- Adult AIDS/HIV Confidential Case Report (PDF)
- After-Hours Sample Script - Chinese (Traditional) (PDF)
- After-Hours Sample Script - Chinese (Simplified) (PDF)
- After-Hours Sample Script - English (PDF)
- After-Hours Sample Script - Spanish (PDF)
- Applied Behavioral Analysis (ABA) Prior Authorization Request Form (PDF)
- Autism Spectrum Diagnosis (ASD) Confirmation of Diagnosis Form (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)
- Confidential Morbidity Report (PDF)

D

- 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)
- eviCore Quick Reference Guide (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 - Advanced 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

- Outpatient California Health Net Commercial Prior Authorization (PDF)

P

- Palliative and Hospice Care Contracted Provider List (PDF)
- 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)
- Provider Notification of Pregnancy - Commercial (PDF)

Q

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)

V

Verifying Eligibility (Individual and Family Plans) (PDF)

W

X

Y

Z

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Bright Futures.
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE									
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	●	★	●	★	★	★	★
Hearing		●[8]	●[9]	⟷	⟷	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	⟷	●[10]	⟷	⟷	●	⟷	⟷	⟷	●	⟷
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																					★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																						●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20]	⟷																											
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	⟷	●	⟷	★	★	★	★	★	⟷		●	⟷
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	⟷	●	⟷	★	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]				⟷	⟷	⟷	⟷	●	⟷	⟷	⟷	⟷	⟷	⟷	⟷																
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟷ = range during which a service may be provided

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

非營業時間腳本範例

醫師和醫療團體可以使用下列腳本之一做為範本，確保即使在非營業時間或診所休診時間 Health Net 會員仍可及時取得醫療照護。

重要：在非營業時間提供有效率的電話服務可確保會員來電時能在 30 秒內接通電話服務人員或答錄機服務。

I. 電話服務人員接聽電話 (例如代客接聽電話服務或集中檢傷分類服務)：

如果來電會員認為自己發生醫療緊急情況，請告訴來電會員先掛斷電話，然後馬上撥 911 或前往最近的急診室 / 醫療機構。

如果來電會員認為情況緊急，或表示需要和醫師通話，請採取以下一項或多項動作，協助聯絡醫師：

- 暫時保留來電會員的電話，然後把來電會員轉接給待命醫師
- 留下來電會員的電話號碼，並告訴來電會員，醫師會在 30 分鐘內回電 (立即傳送訊息給醫師)
- 把待命醫師的傳呼號碼給來電會員，並告訴來電會員，醫師會在 30 分鐘內回會員電話；或指示來電會員前往最近的緊急照護中心
- 如果來電會員表示需要口譯服務，請使用口譯服務以協助聯絡

範例：

您好，這裡是<姓氏>醫師的<代客接聽電話服務 I 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請別掛斷，我會幫您轉接電話。

您好，這裡是<姓氏>醫師的<代客接聽電話服務 I 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，<姓氏>醫師可以協助您。請<傳呼 I 撥打> <電話號碼> 聯絡醫師。您應該會在 30 分鐘內接到回電。

II.答錄機接聽電話：

您好，這裡是 <輸入醫師姓名 I 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話 (選擇適當的選項)：

- *請稍候，我們會為您轉接<姓氏>醫師。*
- *您可以撥 <電話號碼> 直接聯絡待命醫師。*
- *請按 <號碼>，就可以轉接我們的緊急照護中心。我們緊急照護中心的地址是 <緊急照護中心地址> (應針對該地點提供適當的語言選項。)*
- *請按 <號碼>，就可以傳呼待命醫師。您應該會在 30 分鐘內接到回電。*

範例：

您好，這裡是 <醫師 I 醫療團體名稱> 的<姓氏>醫師。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請留下您的姓名、電話號碼，以及來電的原因，您應該會在 30 分鐘內接到回電。

您好，這裡是 <醫師姓名 I 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，您可以撥 <電話號碼> 或按 <號碼> 進行傳呼，就可以直接聯絡待命醫師。您應該會在 30 分鐘內接到回電。

非营业时间示例话术

以下任一话术均可供医生或医疗团队作为模板使用，确保在非营业时间或诊所关闭时，保户仍能及时获得医疗服务。

重要提示：有效的非营业时间电话服务应确保来电者在 30 秒内接通人工服务或自动留言系统。

I. 人工接听来电（如电话接听服务或集中分诊中心）：

如果来电者认为自己正处于医疗紧急情况，请告知其立即挂断电话并拨打 911，或前往最近的急诊室/医疗机构。

如果来电者认为情况紧急，或表示希望与医生通话，请通过以下一种或多种方式协助其联系医生：

- 让来电者暂时不要挂断电话，然后将其转接至值班医生
- 记录来电者的电话号码，并告知医生将在 30 分钟内回电（请立即将信息发送给医生）
- 为来电者提供值班医生的呼叫器号码，并告知其医生将在 30 分钟内回电；或者将来电者引导至最近的急诊护理中心
- 如来电者表示需要口译服务，请协助其获取相应的口译支持

示例：

您好，您已拨通 <Last Name> 医生的<电话接听服务/集中分诊中心>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，请保持在线，我将为您转接。

您好，您已拨通 <Last name> 医生的<电话接听服务/集中分诊中心>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，<Last Name> 医生可为您提供帮助。请通过 <telephone number> 联系其<呼叫器/电话>。您将在 30 分钟内收到回电。

II. 电话由自动留言系统接听：

您好，您已拨通 <insert Name of Doctor/Medical Group>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话（请选择相应选项）：

- 请稍候，我们将为您转接 <Last Name> 医生
- 您可直接拨打 <telephone number> 联系值班医生
- 请按 <number> 转接至我们的急诊护理中心。我们的急诊护理中心位于 <urgent care center address>（应提供该地址的其他语言版本）。
- 请按 <number> 呼叫值班医生。您将在 30 分钟内收到回电

示例：

您好，您已拨通 <Last Name> 医生所属的 <Name of Doctor/Medical Group>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，请留言说明您的姓名、电话以及来电原因，您将在 30 分钟内收到回电。

您好，您已拨通 <Name of Doctor/Medical Group>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，可直接拨打 <telephone number>，或按 <number> 呼叫值班医生。您将在 30 分钟内收到回电。

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within 30 minutes (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within 30 minutes, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>.You may expect a call back within 30 minutes.

II. CALLS ANSWERED BY AN ANSWERING MACHINE:

Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within 30 minutes*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within 30 minutes.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within 30 minutes.

EJEMPLO DE TEXTO PARA USAR FUERA DEL HORARIO DE ATENCIÓN

Los médicos y grupos médicos pueden utilizar uno de los siguientes textos como plantilla para garantizar que los afiliados a Health Net tengan acceso a una atención médica oportuna fuera del horario de atención o cuando sus consultorios están cerrados.

IMPORTANTE: Un servicio telefónico eficaz fuera del horario de atención garantiza que las personas que llaman puedan comunicarse con una voz en vivo o un contestador automático dentro de los 30 segundos.

I. LLAMADAS RESPONDIDAS POR UNA VOZ EN VIVO (como un servicio de mensajes telefónicos o un servicio centralizado de clasificación según las prioridades de atención):

Si la persona que llama cree que está teniendo una emergencia médica, indíquele que cuelgue y que llame al 911 de inmediato, o bien, que se dirija a la sala de emergencias/al centro médico más cercano.

Si la persona que llama cree que la situación es de urgencia o indica que necesita hablar con un médico, póngala en contacto con el médico siguiendo uno o más de los pasos a continuación:

- Déjela en espera por un momento y luego comuníquela con el médico de guardia
- Solicítele el número de teléfono e indíquele que un médico le devolverá la llamada dentro de los 30 minutos (envíe un mensaje al médico de inmediato)
- Proporciónele el número del buscapersonas del médico de guardia e indíquele que el médico llamará al afiliado dentro de los 30 minutos, o bien, diríjala al centro de atención de urgencia más cercano
- Si una persona que llama indica que necesita servicios de intérprete, póngala en contacto con quien pueda brindarle dichos servicios

Ejemplos:
Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, permanezca en línea mientras le comunico.

Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, el Dr./la Dra. <Apellido> puede ayudarle. Por favor, <llámelo/a> al <número de teléfono>. Calcule que se le devolverá la llamada dentro de los 30 minutos.

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMÁTICO:

Hola, usted se ha comunicado con <insertar el nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia (seleccione la opción correspondiente):

- *Por favor, espere un momento mientras le comunico con el Dr./la Dra. <Apellido>*
- *Usted puede comunicarse directamente con el médico de guardia llamando al <número de teléfono>*
- *Oprima <número> para transferir la llamada a nuestro centro de atención de urgencia, que está ubicado en <dirección del centro de atención de urgencia> (Se deben proporcionar las opciones de idioma correspondientes a la ubicación.)*
- *Oprima <número> para llamar al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.*

Ejemplos:
Hola, usted se ha comunicado con <Nombre del Médico/Group Médico> para el Dr./la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, deje un mensaje con su nombre, su número de teléfono y el motivo por el que llama, y calcule que se le devolverá la llamada dentro de los 30 minutos.

Hola, usted se ha comunicado con <Nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, puede comunicarse directamente con éste llamando al <número de teléfono> u oprimiendo <número> para acceder al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.

Applied Behavioral Analysis (ABA) Prior Authorization Request Form

Provider facility/group name: _____

Provider taxpayer identification number (TIN): _____

Provider address: _____ **Provider city, state, zip:** _____

Provider phone #: _____ **Provider fax number:** _____

Case supervisor name and credentials: _____

Case supervisor national provider identifier (NPI): _____

Case supervisor phone number: _____ **Case supervisor email:** _____

Case supervisor availability for call back (*please indicate days and times*): _____

Member ID number: _____ **Member DOB:** _____

Member first name: _____ **Member last name:** _____

Member address: _____

Proposed authorization start date: _____ **Proposed authorization end date:** _____

Addendums to existing authorizations can no longer be accommodated. If you require changes to your current authorization, such as adjustments to dates of service or hours, a new prior authorization request form must be submitted for utilization review. As a result, the existing authorization will be ended.

Please ensure the prior authorization request form is completed in its entirety, rather than only including the additional hours or codes needed. The start date should be the date the change is needed, and the end date must correspond to the end date of the current authorization. Please include all codes you plan to deliver and the total hours per week/month needed for the remaining weeks (not just the additional hours or codes needed). Lastly, you must include a letter detailing the clinical rationale that supports the request for an increase in hours and/or changes in dates of service.

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HCPCS Codes

H0031	_____	**Hours** per auth period.		
H0032	_____	**Hours** per	Week	Month
H2014	_____	**Hours** per	Week	Month
H2019	_____	**Hours** per	Week	Month
S5111	_____	**Sessions** per	Week	Month

CPT Codes

97151	_____	**Hours** per auth period.		
97152	_____	**Hours** per auth period.		
0362T	_____	**Hours** per auth period.		
97153	_____	**Hours** per	Week	Month
97154	_____	**Hours** per	Week	Month
97155	_____	**Hours** per	Week	Month
97156	_____	**Hours** per	Week	Month
97157	_____	**Hours** per	Week	Month
97158	_____	**Hours** per	Week	Month
0373T	_____	**Hours** per	Week	Month

Submit the completed form to the Health Net* Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.

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Confirmation of Diagnosis: Autism Spectrum Diagnosis (ASD)

For a list of in-network providers, contact Health Net* Behavioral Health at 888-935-5966.

This form must be completed by a physician or licensed psychologist. Please attach a copy of the member's most recent face-to-face evaluation and any additional supporting documentation (e.g., comprehensive diagnostic evaluation).

Member ID number: _____ **Member DOB:** _____
Member first name: _____ **Member last name:** _____
Member address: _____

Parent/caregiver name: _____ **Relationship to member:** _____
Phone number: _____

Diagnosis: Autism Spectrum Disorder (ASD) and/or other: _____
Date of diagnosis: _____

ASD diagnosis was confirmed by one of the following screening tools:

Checklist for autism in toddlers (CHAT).
Modified checklist for autism in toddlers/modified checklist for autism in toddlers, revised with follow-up (M-CHAT/M-CHAT-R/F).
Screening tool for autism in toddlers & young children (STAT).
Social communication questionnaire (SCQ).
Autism spectrum screening questionnaire (ASSQ).
Childhood autism spectrum test, formerly known as the childhood Asperger's syndrome test (CAST).
Krug Asperger's disorder index (KADI).
Autism diagnostic observation schedule/autism diagnostic observation schedule 2nd edition (ADOS/ADOS-2).
Autism diagnostic interview revised (ADI-R).
Childhood autism rating scale/ childhood autism rating scale 2nd edition (CARS/CARS-2).
Gilliam autism rating scale (GARS-3).
Other valid form of approved evidence-based assessment result/summary – see attached:

Diagnosing physician/clinician name: _____
Contact phone number: _____
Applied behavior analysis (ABA) recommended: Yes No
Additional/alternative treatment recommendation(s): _____
Signature of physician or licensed psychologist: _____
License type and ID number: _____
Date: _____

Submit the completed form to the Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.

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Autoclave Maintenance and Run Log -- Year _____

Please Date and Initial

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
MONTHLY SPORE TESTING RESULTS												
MONTHLY CLEANING												
ANNUAL CALIBRATION												

Sterility is **EVENT related**, not time related; Pack is considers sterile unless and event causes contamination (example: punctured, torn, cracked packs = unsterile; evidence of water damage or yellowed packs = unsterile). Have process to routine evaluation of sterile packs
Log Process: Write date and Load # on Pack (if more than 1 load is run in the same day, write date and load #1 and then date and load #2 etc)

Date	Time	Load #	Item(s) Autoclaved	Temperature (250-254 Degrees)	Steam Pressure (15-17 psi)	Duration of Run (30 minutes)	Person Responsible

Health Net* of California, Inc. Bariatric Surgery Performance Centers				
Northern California				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Ali, M.D., Mohamed	2221 Stockton Blvd., Ste. E Sacramento, CA 95817	(916) 734-2680	U.C. Davis Medical Center[1]	2315 Stockton Blvd. Sacramento, CA 95817
Azagury, M.D., Dan	300 Pasteur Dr. Stanford, CA 94305	(650) 725-9777	Stanford Hospital and Clinic	300 Pasteur Dr. Stanford, CA 94305
Boone, M.D., Keith Valley Surgical Specialists	205 East River Park Circle, Ste. 460 Fresno, CA 93710	(559) 261-4500	Fresno Heart and Surgical Hospital	15 East Audubon Rd. Fresno, CA 93720
Carter, M.D., Jonathan	400 Parnassus Ave., 2nd Floor San Francisco, CA 94143-0338	(415) 353-2161	U.C. San Francisco Medical Center	505 Parnassus Ave., 4th Floor San Francisco, CA 94143
Esquivel, M.D., Micaela	300 Pasteur Dr., H3680 Stanford, CA 94305	(408) 396-7669	Stanford Hospital and Clinic	300 Pasteur Dr. Stanford, CA 94305
Feng, M.D., John J.[2]	790 El Camino Real Palo Alto, CA 94301	(650) 853-6600 (650) 596-4120	El Camino Hospital	2500 Grant Rd. Mountain View, CA 94040
			Mills Peninsula	1783 El Camino Real Burlingame, CA 94010
Higa, M.D., Kelvin Valley Surgical Specialists	205 East River Park Circle, Ste. 460 Fresno, CA 93710	(559) 261-4500	Fresno Heart and Surgical Hospital	15 East Audubon Rd. Fresno, CA 93720
Khalil, M.D., Beeman[2]	795 El Camino Real Palo Alto, CA 94301	(650) 853-5340	El Camino Hospital	2500 Grant Rd. Mountain View, CA 94040
	3200 Kearney St. Fremont, CA 94538	(510) 490-1222		
Kim, M.D., Teresa[2]	365 Hawthorne Ave., Ste. 101 Oakland, CA 94609	(510) 465-5523	Alta Bates Summit	350 Hawthorne Ave. Oakland, CA 94609

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Health Net of California, Inc. Bariatric Surgery Performance Centers				
Northern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Legha, M.D., Prithvi[2]	701 E. El Camino Real Mountain View, CA 94040	(650) 404-8400	El Camino Hospital	2500 Grant Rd. Mountain View, CA 94040
Patching, M.D., Steven C. [2]	1737 Creekside Dr. Folsom, CA 95630	(916) 932-0315	Methodist Hospital	7500 Hospital Dr. Sacramento, CA 95823
	800 Howe Ave, Ste. 300 Sacramento, CA 95825	(916) 568-5564	Sutter General Hospital	2801 L St. Sacramento, CA 95816
Posselt, M.D., Andrew	400 Parnassus Ave., 2nd Floor San Francisco, CA 94143	(415) 353-2161	UCSF Medical Center	505 Parnassus Ave., 4th Floor San Francisco, CA 94143
Reddy, M.D., Subhash[2]	3 Medical Plaza, Ste. 200 Roseville, CA 95661	(916) 773-8750	Sutter Roseville Medical Center	1 Medical Plaza Roseville, CA 95661
Rogers, M.D., Stanley	400 Parnassus Ave., 2nd Floor San Francisco, CA 94143	(415) 353-2161	UCSF Medical Center	505 Parnassus Ave., 4th Floor San Francisco, CA 94143
Shadle, M.D., Benjamin D.	3 Medical Plaza, Ste. 200 Roseville, CA 95661	(916) 773-8750	Sutter Roseville Medical Center	1 Medical Plaza Roseville, CA 95661
	400 Plumas Blvd., Ste. 215 Yuba City, CA 95991			
Upadhyay, M.D., Ajay	365 Hawthorne Ave., Ste. 101 Oakland, CA 94609	(510) 465-5523	Alta Bates Summit	350 Hawthorne Ave. Oakland, CA 94609

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Ali, M.D., Mir B. LePort Surgical Associates	18111 Brookhurst St., Ste. 5600 Fountain Valley, CA 92708	(714) 861-4666	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Bernstein, M.D, David	401 East Highland Ave., Ste. 351 San Bernardino, CA 92404	(909) 475-8611	St. Bernardine Medical Center	2101 North Waterman Ave. San Bernardino, CA 92404
Bhoyrul, M.D., Sunil	9850 Genesee Ave., Ste. 570 La Jolla, CA 92037	(858) 457-4917	Scripps La Jolla	10140 Campus Point Dr. San Diego, CA 92121
Billy, M.D., Helmuth	3200 Telegraph Rd. Ventura, CA 93003	(805) 676-9100	St. John's Regional Hospital	1600 N. Rose St. Oxnard, CA 93030
Braverman, M.D., Justin	12462 Putnam St., Ste. 500 Whittier, CA 90602	(562) 789-5449	PIH Whittier	12401 Washington Blvd. Whittier, CA 90602
Broderick, M.D., Ryan	9300 Campus Point Drive Ste. 7220 La Jolla, CA, 92037	(858) 657-7146	University of California, San Diego Health Jacobs Medical Center	9300 Campus Point Dr. La Jolla, CA 92037
Chen, M.D., Yijun	200 UCLA Medical Plaza Ste. 214 Los Angeles, CA 90095	(310) 794-7788	Ronald Regan UCLA Medical Center	757 Westwood Plaza Los Angeles, CA 90095
Daly, M.D., Shaun	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868
Dutson, M.D., Erik	200 UCLA Medical Plaza, Ste. 214 Los Angeles, CA 90095	(310) 794-7788	Ronald Reagan UCLA Medical Center	757 Westwood Plaza Los Angeles, CA 90095
Ellner, M.D., Julie	5555 Reservoir Dr., Ste. 203 San Diego, CA 92120	(619) 229-3340	Alvarado Hospital Medical Center	6655 Alvarado Rd. San Diego, CA 92120

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Francis, M.D., Kelly	18111 Brookhurst St., Ste. 6400 Fountain Valley, CA 92708	(714) 350-7258	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Fuller, M.D., William	10666 N. Torrey Pines Rd., MS 213 La Jolla, CA 92037	(714) 861-4666	Scripps Mercy Hospital	4077 Fifth Ave., Mer 7 San Diego, CA 92103
			Scripps Green Hospital	10666 North Torrey Pines Rd. La Jolla, CA 92037
Hinojosa, M.D., Marcelo	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868
Jacobsen, M.D., Garth	UCSD Health – La Jolla UTC 4303 La Jolla Village Dr Ste. 2110 La Jolla, CA 92112	(858) 657-8860	University of California, San Diego Health Jacobs Medical Center	9300 Campus Point Dr. La Jolla, CA 92037
Krahn, M.D., Douglas	401 East Highland Ave., Ste. 351 San Bernardino, CA 92404	(909) 475-8611	Chapman Medical Center	2601 E. Chapman Ave. Orange, CA 92869
			St. Bernardine Medical Center	2101 North Waterman Ave. San Bernardino, CA 92404
Lamar, M.D., Troy California Bariatric & General Surgery	51 N. 5th Ave., Ste. 202 Arcadia, CA 91006	(626) 445-0600	Methodist Hospital	300 West Huntington Dr. Arcadia, CA 91007

Health Net of California Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Lim, M.D., Lian	10666 N. Torrey Pines Rd., MS 213 La Jolla, CA 92037	(858) 554-8984	Scripps Mercy Hospital	4077 Fifth Ave., Mer 7 San Diego, CA 92103
Mueller, M.D., George	7910 Frost St., Ste. 250 San Diego, CA 92123	(858) 565-0104	Sharp Memorial Hospital	7901 Frost St. San Diego, CA 92123
Nguyen, M.D., Ninh	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868
Oliak, M.D., David	255 West Central Ave., Ste. 203 Brea, CA 92821	(714) 582-2530	Chapman Medical Center	2601 E. Chapman Ave. Orange, CA 92869
Paya, M.D., Mahbod	7320 Woodlake Ave., Ste. 170 West Hills, CA 91307	(818) 888-7090	West Hills Hospital Medical Center	7300 Medical Center Dr. West Hills, CA 91307
Quilici, M.D., Philippe	201 South Buena Vista St., Ste. 425 Burbank, CA 91505	(818) 848-8311	Providence St. Joseph Medical Center	501 S. Buena Vista Burbank, CA 91505
Russo, M.D., Michael	18111 Brookhurst St., Ste. 5600 Fountain Valley, CA 92708	(714) 861-4666	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Samakar, M.D., Kamran	1450 San Pablo St., 6th Floor Los Angeles, CA 90033	(800) 872-2273	University of Southern California (USC)	1500 San Pablo St. Los Angeles, CA 90033
Smith, M.D., Brian	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868
Suh, M.D., David	2083 Compton Ave., Ste. 104 Corona, CA 92881	(951) 256-8191	Inland Regional Valley Medical Center	36485 Inland Valley Dr. Wildomar, CA 92595
	25495 Medical Center Dr., Ste.203 Murietta, CA 92562			

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Takata, M.D., Mark	10666 N. Torrey Pines Rd., MS 213 La Jolla, CA 92037	(714) 861-4666	Scripps Green Hospital	10666 North Torrey Pines Rd. La Jolla, CA 92037
Thoman, M.D., David	520 W. Junipero St. Santa Barbara, CA 93105	(805) 730-1470	Santa Barbara Cottage Hospital	2400 Bath St. Santa Barbara, CA 93105
Wittgrove, M.D., Alan	12865 Point Del Mar Way, Ste. 130 Del Mar, CA 92014	(858) 350-4700	Scripps La Jolla	10140 Campus Point Dr. San Diego, CA 92121

[1]U.C. Davis Medical Center is limited to performing Roux-en-y gastric bypass and revision gastric bypass surgeries for participating Health Net members not capitated by U.C. Davis Medical Group.
[2]Limited to providing bariatric surgery services to Sutter Health Net members only.

Care Management Referral Form

DIRECTIONS: Select the member's plan below and email or fax the completed referral.

- **CA Commercial (Ambetter HMO/PPO, Employer Group plans (HMO, PPO, POS)) and Medicare Employer Groups** – Email completed form to Case.Management.Referrals@healthnet.com or fax completed form to **800-745-6955**.
- **CA Medicare** (including Medicare Advantage) for shared risk non-delegated plans. – Email completed form to centenecmescalationsmedicare@centene.com or fax completed form to **866-290-5957** for physical health and behavioral health care management.
- **CA Medi-Cal** – Email completed form to **CASHP.ACM.CMA@healthnet.com** or fax completed form to **866-581-0540**.
- **Referral to palliative care** – Email completed form to CareConnections@Healthnet.com.

☐ *URGENT Request* ☐ UC Blue & Gold Plan Member

Part 1: Referring Source

First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information

Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP Code:
Member phone number:		

Member Diagnosis/Health Condition (check all that apply):

- ☐ Asthma
- ☐ Back pain
- ☐ Behavioral health
  - ☐ Anxiety
  - ☐ Autism
  - ☐ Depression
  - ☐ Other (specify) _____
- ☐ Bursitis/tendonitis
- ☐ CAD
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Clinical Trials
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Frozen shoulder
- ☐ Golf/tennis elbow
- ☐ Heart failure
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High risk pregnancy
  Estimated date of delivery __/__/__
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Migraine/tension headache
- ☐ Musculoskeletal
- ☐ Obesity-weight management
- ☐ Osteoarthritis
- ☐ Prematurity and/or developmental delay
- ☐ Rheumatoid arthritis
- ☐ Sickle cell
- ☐ Transplant
- ☐ Traumatic brain injury
- ☐ Other: _____

Please check if any of the following referral reasons apply to the member:

- ☐ Member needs assistance with palliative care: _____
- ☐ Concerned about high emergency room utilization or frequent hospitalizations.
- ☐ Exhaustion of benefits.
- ☐ Member needs assistance with behavioral health needs.
- ☐ Member needs assistance with medical equipment.
- ☐ Member needs assistance with resources for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
- ☐ Member needs education on prescriptions and compliance.
- ☐ Member needs education/support with managing his/her chronic condition(s).
- ☐ Member needs prenatal care education and support services.
- ☐ Member needs transportation to medical appointments.
- ☐ Safety concerns.
- ☐ Other (specify) _____

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Please use this page to provide additional information (as needed).

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Authorized Representative	Date
_____	_____
Type or Print Name	Name of Provider
_____	_____
Title	Address

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | **Age** | ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** *(mm/dd/yyyy)* | **Country of Birth**

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | **Date of First Specimen Collection** *(mm/dd/yyyy)* | **Date of Diagnosis** *(mm/dd/yyyy)* | **Date of Death** *(mm/dd/yyyy)*

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | **City** | **State** | **ZIP Code**

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis?
☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

Diagnostic Evaluation/ Assessment Form

To be completed by MD or Licensed Psychologist

Information provided is protected in accordance with HIPAA requirements and other applicable confidentiality regulations.

Health Net Medical Management Department
Fax: 1-800-672-2135 Telephone: 1-800-977-7282

Part I. Patient information

Last name:	First name:
Patient's DOB:	Subscriber ID #:

Part II. Requesting provider information

Name:	Specialty:	Tax ID / NPI:	
Street address:			
City:		State:	ZIP:
Telephone:	Email address:	Fax #:	

Part III. Servicing provider information

Name:	Specialty:	Tax ID / NPI:	
Street address:			
City:		State:	ZIP:
Telephone:	Email address:	Fax #:	

Part IV. Evaluation/assessment information

Date of evaluation/assessment:
Summary and recommendations: *(For additional information, please include a separate page.)*

(continued)

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Part IV. Evaluation/assessment information (continued)

Diagnosis: *(All five axes must be completed.)*

ICD10 Code: _____ CPT Code: _____

Axis I: _____
(Clinical Disorders)

Axis II: _____
(Personality Disorders/Mental Retardation)

Axis III: _____
(Medical Conditions)

Axis IV: _____
(Psychosocial/Environmental Problems)

Axis V: _____
(GAF)

Provider signature:	Date:

- Prior authorization/certification is not required during the initial six months of behavioral health treatment for pervasive developmental disorder (PDD) or autism spectrum disorder (ASD); however, prior notification is required. **Notification must include documentation that a licensed physician or licensed psychologist has established the diagnosis of PDD or ASD and a copy of the treatment plan.**
- Fax this completed Diagnostic Evaluation/Assessment form along with the required Initial Treatment Plan to the number indicated on the front. The Initial Treatment Plan should include a description of the patient's behavioral health impairment(s) to be treated, measurable goals over a specified timeline, service type/treatment to be utilized, number of hours, and parent participation needed to achieve the goals and objectives. Interventions utilized should be evidence-based with demonstrated clinical efficacy.
- The treatment plan is to be reviewed in six months and no less than every six months thereafter by the qualified autism service provider and modified whenever appropriate.
- Prior authorization is required for continued behavioral health treatment beyond the first six months and every six months thereafter. Requests for authorization must include an updated treatment plan from the qualified autism service provider. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
- Health Net may deny requests for authorization and coverage of continued behavioral health treatment if the requirements above are not met or if ongoing clinical efficacy of the treatment is not demonstrated.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，或撥 1-800-522-0088。如需其他協助：如果您投保的是 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi Trung tâm Liên lạc Hội viên của Health Net theo số 1-800-522-0088. Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화해 주시거나 Health Net의 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의해 주십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa nakalistang numero sa iyong ID card o sa Customer Contact Center ng Health Net sa 1-800-522-0088. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tumawag sa DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Հավելյալ օգնության համար՝ եթե գրանցվել եք PPO կամ EPO ապահովագրական ծրագրում, որի մատակարարն է Health Net Life Insurance Company-ն, 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance): Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

無料の言語サービス。日本語の通訳が書類をお読みします。サービスをご希望の方は、IDカード記載の番号まで、またはHealth Netの顧客コンタクト・センター、1-800-522-0088までお電話ください。さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、DMHCヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте или в Контактный центр для клиентов компании Health Net (Customer Contact Center) по телефону 1-800-522-0088. Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا مرکز تماس مشتریان Health Net به شماره 1-800-522-0088 تماس بگیرید. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਇਹ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬមិត្តប្រុលទំនាក់ទំនងអតិថិជនរបស់ Health Net តាមលេខ 1-800-522-0088។ សំរាប់ជំនួយ បន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងច្បាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc. ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu tuaj rau peb ntawm tus xovtooj uas nyob ntawm koj daim npav ID lossis Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh 'Alínígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áá ni nizaad bee hadadilyaago nich'į' yídóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' béésh bee haneí biká'ígíí bee nich'į' hodíilnih, doodago ninaalishí bił hada'dil'ínígíí t'áá shǫǫdí Health Net Na'iiłniihí Hane' 'Íił'íh Bił Haz'áníjį' 1-800-522-0088 hodíilnih.T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'ąąh naa'nil bibee haz'áanii Health Net Life Insurance Company bich'į' haidiilaaígíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'áchąąh naa'nil bił haz'ánígíí bich'į' kohjį' ąǫįóóǫįąíǫéąęí hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohjį'1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nitł'izí bine'dęę' bikáá'.

Navajo

الخدمات اللغوية المجانية. يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك أو الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تضمنها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

FRM000464ZH00 (1/15) ca_comm_nola_mbr_off-ex_EPO

HNCA CODE LISTS - *By Modality and In Numerical Order*

COMPLETE CODE LIST

The Lists are in Numerical Order and divided by Modality below:

CT/CTA

CT - Computed Tomography

CTA - Computed Tomography Angiography

MRI/MRA

MRI - Magnetic Resonance Imaging

MRA - Magnetic Resonance Angiography

NOTE: NCM-MPI-MUGA included for **HNCA HMO** members starting 1-1-14

NCM – MPI – MUGA

Nuclear Cardiac Medicine (NCM)

Myocardial Perfusion Imaging(MPI)

MUGA, [aka: Blood Pool Imaging]

PET & PET/CT

PET and PET/CT - *Positron Emission Tomography*

3D RENDERING

SLEEP STUDIES

HNCA CODE LISTS - *By Modality and In Numerical Order*

CT - Computed Tomography			
0042T	Cerebral perfusion analysis using CT with contrast administration,		
70450	CT Head without contrast	**70460**	CT Head with contrast
70470	CT Head with & without contrast W & W/O		
70480	CT Orbit, sella, or posterior fossa or outer, middle, or inner ear W/O		
70481	CT Orbit, sella, or posterior fossa or outer, middle, or inner ear with contrast		
70482	CT Orbit, sella, or posterior fossa or outer, middle, or inner ear W & W/O		
70486	CT Maxillofacial area, (sinus) without contrast		
70487	CT Maxillofacial area, (sinus) with contrast		
70488	CT Maxillofacial area, (sinus) with & without contrast W & W/O		
70490	CT Soft-tissue Neck W/O	**70491**	CT Soft-tissue Neck with contrast
70492	CT Soft-tissue Neck with & without contrast W & W/O		
71250	CT Chest without contrast	**71260**	CT Chest with contrast
71270	CT Chest with and without contrast W & W/O		
72125	CT Cervical Spine W/O	**72126**	CT Cervical Spine with contrast
72127	CT Cervical Spine with and without contrast W & W/O		
72128	CT Thoracic Spine W/O	**72129**	CT Thoracic Spine with contrast
72130	CT Thoracic Spine with and without contrast W & W/O		
72131	CT Lumbar Spine W/O	**72132**	CT Lumbar Spine with contrast
72133	CT Lumbar Spine with and without out contrast W & W/O		
72192	CT Pelvis W/O	**72193**	CT Pelvis with contrast
72194	CT Pelvis with and without contrast W & W/O		
73200	CT Upper Extremity W/O	**73201**	CT Upper Extremity with contrast
73202	CT Upper Extremity with and without contrast W & W/O		
73700	CT Lower Extremity W/O	**73701**	CT Lower Extremity with contrast
73702	CT Lower Extremity with and without contrast W & W/O		
74150	CT Abdomen W/O	**74160**	CT Abdomen with contrast
74170	CT Abdomen with and without contrast W & W/O		
74176	CT ABDOMEN and PELVIS; without contrast		
74177	CT ABDOMEN and PELVIS; with contrast		
74178	CT ABDOMEN and PELVIS; with & without contrast		
74261	CT Colonography, diagnostic; without contrast material		
74262	CT Colonography, diagnostic; with contrast material		
74263	CT Colonography, screening, including image postprocessing		
75571	CT, HEART, without contrast with quantitative evaluation of coronary calcium		
75572	CT, heart, with contrast, for evaluation of cardiac structure and morphology		
75573	CT, heart, with contrast, for evaluation of cardiac structure and morphology in the setting of congenital heart disease		
75574	CT, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing		
76380	CT Limited or Localized follow-up		
76497	Unlisted CT procedure (e.g., diagnostic, interventional)		
77078	CT BONE MINERAL DENSITY study, 1 or more sites, axial skeleton		
S8092	CT ELECTRON BEAM (also known as Ultrafast CT, Cine CT)		

RETURN

HNCA CODE LISTS - *By Modality and In Numerical Order*

CTA - Computed Tomographic Angiography			
70496	CT Angiography (CTA), Head- includes post-processing		
70498	CT Angiography (CTA), Neck-includes post-processing		
71275	CT Angiography (CTA), Chest (NON-CORONARY) includes post-processing		
72191	CT Angiography (CTA) Pelvis-includes post-processing		
73206	CT Angiography (CTA) Upper Extremity-includes post-processing		
73706	CT Angiography (CTA) Lower Extremity- includes post-processing		
74174	CT Angiography (CTA) Abdomen and Pelvis- W & W/O includes post-processing		
74175	CT Angiography (CTA) Abdomen- W & W/O includes post-processing		
75635	CT Angiography (CTA) Abdominal Aorta and bilateral iliofemoral lower extremity runoff		
MRI – Magnetic Resonance Imaging			
0159T	CAD for BREAST MRI	**70336**	MRI Temporomandibular Joint(s) TMJ
70540	MRI Orbit, Face and/or Neck W/O	**70542**	MRI Orbit, Face and/or Neck with contrast
70543	MRI Orbit, Face and/or Neck with and without contrast W & W/O		
70551	MRI Brain (Head) W/O	**70552**	MRI Brain (Head) with contrast
70553	MRI Brain (Head) with and without contrast W & W/O		
70554	MRI Brain, **functional MRI**; not requiring physician or psychologist		
70555	MRI, Brain, **functional MRI;** requiring physician or psychologist		
71550	MRI Chest W/O	**71551**	MRI Chest with contrast
71552	MRI Chest with and without contrast W & W/O		
72141	MRI Cervical Spine W/O	**72142**	MRI Cervical Spine with contrast
72146	MRI Thoracic Spine W/O	**72147**	MRI Thoracic Spine with contrast
72148	MRI Lumbar Spine W/O	**72149**	MRI Lumbar Spine with contrast
72156	MRI Cervical Spine with and without contrast W & W/O		
72157	MRI Thoracic Spine with and without contrast W & W/O		
72158	MRI Lumbar Spine with and without contrast W & W/O		
72195	MRI Pelvis W/O	**72196**	MRI Pelvis with contrast
72197	MRI Pelvis with and without contrast W & W/O		
73218	MRI Upper Extremity-*other than joint*-without contrast		
73219	MRI Upper Extremity-*other than joint*-with contrast		
73220	MRI Upper Extremity-*other than joint*-with and without contrast W & W/O		
73221	MRI Any Joint Upper Extremity W/O	**73222**	MRI Any Joint Upper Extremity--with contrast
73223	MRI Any Joint of Upper Extremity—with and without contrast W & W/O		
73718	MRI Lower Extremity-*other than joint*-without contrast		
73719	MRI Lower Extremity-*other than joint*-with contrast		
73720	MRI Lower Extremity-*other than joint*-with and without contrast W & W/O		
73721	MRI Any Joint of Lower Extremity W/O	**73722**	MRI Any Joint of Lower Extremity--with
73723	MRI Any Joint of Lower Extremity—with and without contrast W & W/O		
74181	MRI Abdomen W/O	**74182**	MRI Abdomen with contrast
74183	MRI Abdomen with and without contrast W & W/O		
75557	Cardiac MRI for morphology and function without contrast materials		
75559	Cardiac MRI for morphology and function without contrast materials; with stress imaging		
75561	Cardiac MRI for morphology and function WO, followed by contrast		
75563	Cardiac MRI for morphology and function WO, followed by contrast; with stress imaging		
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately)		
76390	MR Spectroscopy (MRS)		
76498	Unlisted MR procedure (eg, diagnostic, interventional)		
77058	MRI BREAST, UNILATERAL	**77059**	MRI BREAST, BILATERAL

RETURN

HNCA CODE LISTS - *By Modality and In Numerical Order*

MRI – Magnetic Resonance Imaging	
77084	MRI Bone Marrow blood supply
S8035	Magnetic source imaging
S8037	MRCP (Magnetic Resonance Cholangiopancreatography)
S8042	MRI Low-Field

MRA – Magnetic Resonance Angiography			
70544	MRA Head without contrast	**70545**	MRA Head with contrast
70546	MR Angiography (MRA) Head with and without contrast W & W/O		
70547	MRA Neck without contrast	**70548**	MRA Neck with contrast
70549	MR Angiography (MRA) Neck with and without contrast W & W/O		
71555	MR Angiography (MRA) Chest (excluding myocardium)- W or W/O		
72159	MR Angiography (MRA) Spinal Canal and contents		
72198	MR Angiography (MRA) Pelvis -with or without contrast		
73225	MR Angiography (MRA) Upper Extremity -with or without contrast		
73725	MR Angiography (MRA) Lower Extremity-with or without contrast		
74185	MR Angiography (MRA) Abdomen-with or without contrast		

MPI – *Myocardial Perfusion Imaging* NCM – *Nuclear Cardiac Imaging*	
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative **wall motion**, **ejection fraction** by first pass or gated technique, additional quantification, when performed); **single study, at rest or stress**
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative **wall motion**, **ejection fraction** by first pass or gated technique, additional quantification, when performed); **multiple studies, at rest and/or stress**
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); **single study, at rest or stress**
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); **multiple studies, at rest and/or stress**
78466	Myocardial Imaging, infarct avid, planar; qualitative or quantitative
78468	Myocardial Imaging, infarct avid, planar; w/ EF by first pass technique
78469	Myocardial Imaging, infarct avid, planar; tomographic SPECT
78472	Cardiac Blood Pool imaging, gated equilibrium; planar, single study at rest **or** stress
78473	Cardiac Blood Pool imaging, multiple studies, at rest **and** stress,
78481	Cardiac Blood Pool imaging, (planar), first pass technique; single study, at rest or with stress
78483	Cardiac Blood Pool imaging, (planar), first pass technique; multiple studies at rest and stress
78494	Cardiac Blood Pool imaging, gated equilibrium, SPECT
78496	Cardiac Blood Pool imaging, gated equilibrium, RV EF by first pass
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine

RETURN

HNCA CODE LISTS - *By Modality and In Numerical Order*

PET and PET/CT - Positron Emission Tomography			
78608	PET Brain – metabolic evaluation	**78609**	PET Brain – perfusion evaluation
78459	PET Cardiac–metabolic evaluation	**78491**	PET Cardiac–perfusion, single, rest or stress
78492	PET Cardiac (myocardial imaging), perfusion multiple studies rest/stress		
78811	PET Imaging; limited area (ex: chest, head/neck)		
78812	PET Imaging; skull base to mid-thigh	**78813**	PET Imaging; whole body
78814	PET/CT; limited area (ex: chest, head/neck)		
78815	PET/CT; skull base to mid-thigh	**78816**	PET/CT; whole body

3D RENDERING	
76376	3D rendering- ***not*** *requiring an independent workstation*
76377	3D rendering- *requiring an independent* workstation

SLEEP STUDIES	
95800	Sleep study with recording, unattended
95801	Sleep study with recording, unattended
95805	Sleep Study, multiple trials
95806	Sleep study with recording, unattended
95807	Sleep study with recording, attended by a technologist.
95808	Polysomnography* (Type I); 1-3 additional parameters
95810	Polysomnography* (Type I); 4 or more parameters
95811	Polysomnography* (Type I); 4 or more parameters with airway therapy ventilation
95782	Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783	Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
G0398	Home sleep study test Type II
G0399	Home sleep study test Type III
G0400	Home sleep study test Type IV

RETURN

Directory Removal for At-Risk Providers Form

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

If any of the below applies to you, please initial next to the condition that has been met in order to be omitted from the directory, and sign and date the statement at the bottom. **Please complete and submit this form via secure fax, or scan and email to following:**

Fax number	Email address
1-866-524-1286	faxback.projects@healthnet.com

_____The provider is currently enrolled in the Safe at Home program (www.sos.ca.gov/registries/safe-home).

_____The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.

_____A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.

_____Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Group and/or provider name: _____

National Provider Identifier (NPI): _____

Address: _____

Telephone number: _____

I hereby confirm that the identified condition has been met and I should be omitted from the Health Net provider directory.

_____

Printed name (include title if signing on behalf of a provider group or other similarly situated provider).

_____

Signature Date

Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. and Centene Corporation. Health Net is a registered service mark of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.
18-042/FRM017591EW00 (1/18)

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ **Prime** ☐ **Subawardee** Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount,** *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
Ankle-foot/knee-ankle-foot orthotics	Orthotic replacements are included in the reimbursement for orthotics
Automatic external defibrillators	External defibrillators are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*
Blood glucose monitoring	Glucose monitors/supplies are reimbursable for diabetics only and when reported with the appropriate modifier (KS or KX)
	Continuous noninvasive glucose monitors are considered experimental/investigational because the safety or efficacy of these devices have not been established by review of the available published literature
	A disposable glucose monitor is a non-covered item
Breast prosthesis	A custom breast prosthesis is reimbursed at the rate of a prefabricated breast prosthesis
Canes and crutches	When an underarm, articulating, spring-assisted crutch is provided, it is reimbursed at the rate of an underarm crutch other than wood
	Only one crutch type is covered per date of service
Cervical traction devices	Cervical traction that is free-standing or attached to a headboard is reimbursed at the rate of overdoor cervical traction
	Free-standing cervical traction is eligible for reimbursement coverage when requirements have been met and filed with the appropriate modifier.* Otherwise it is reimbursed at the rate for overdoor cervical traction
Cold therapy	A water circulating cold pad with pump is not eligible for reimbursement because it is considered investigational
Commodes	An extra wide/heavy duty commode chair is reimbursable for a member who weighs 300 pounds or more, when reported with the appropriate modifier.* It is otherwise reimbursable at the rate for a regular commode if basic coverage criteria for a commode chair are met
	A commode chair with detachable arms is reimbursable when the clinical criteria are met and when it is reported with the appropriate modifier*
	A pail or pan for use with commode chair is included in the reimbursement for a commode chair
	A seat-lift mechanism is included in the reimbursement for a commode chair with a seat-lift mechanism

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
Diabetic shoes	Orthopedic shoes and accessories for members with diabetes are reimbursable when reported with codes specific to diabetic footwear
	An insert that is direct formed and molded to a member's foot without an external heat source is a non-covered item
Enteral nutrition	Enteral feeding supply kits are reimbursable once per day
	Additives for enteral formula are included in the reimbursement for enteral formulas
	Components of a more complete kit are included in the reimbursement for the kit
External infusion pumps	Supplies for maintaining a drug infusion catheter are not eligible for reimbursement in the same month as a drug infusion kit
	Components of a more complete kit are included in the reimbursement for the kit
	IV poles are included in the reimbursement of ambulatory infusion pumps
	Replacement batteries for an infusion pump are included in the monthly rental reimbursement of an infusion pump
Hospital headboards and accessories	Hospital bed rental is reimbursable once per month
	Hospital bed accessories that are part of the more complete hospital bed are included in the reimbursement for the hospital bed
	Hospital bed rails are included in the reimbursement for hospital beds with bed rails
	Hospital bed rails and mattresses are included in the reimbursement for hospital beds with bed rails and mattresses in their description
Intrapulmonary percussive ventilation (IPV) systems	Intrapulmonary percussive ventilation systems are not covered in the home, assisted living, group home, or custodial care setting
Lower limb prosthesis	A below-knee suction socket or suction suspension for an above-knee or knee disarticulation socket is not separately reimbursed with a knee suspension locking mechanism
	A custom fabricated socket insert is not eligible for reimbursement when reported with a replacement prosthesis or addition
	Lower extremity diagnostic test sockets are included in reimbursement for immediate prosthesis
	A maximum of two test (diagnostic) sockets for an individual prosthesis is considered for reimbursement.
	Special features for lower limb prosthesis (such as multiaxial ankle/foot, flexfoot system, high activity knee) is considered for reimbursement based on the member's functional level
	Special features/additions added at the time of provision of the preparatory prosthesis are not separately reimbursed

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
	Replacement prosthesis components are not reimbursable when reported with a prosthesis
Manual and power wheelchair accessories	Manual wheelchair accessories are appropriately reported when used with manual wheelchairs
	Power wheelchair accessories are appropriately reported when used with power wheelchairs
Modifiers	Prosthetics and orthotics that can be reported bilaterally require an RT (right) and/or LT (left) modifier
	Lower limb prostheses require a valid and appropriate functional modifier (K0-K4)
	A prosthesis is reimbursable when there is expectation that the amputee reaches or maintains a defined functional state within a reasonable time frame and when reported with the appropriate modifier
	Capped rental modifiers are restricted to usage with items listed as capped rental equipment by the Centers for Medicare and Medicaid Services (CMS)
	Items requiring an order prior to delivery (pressure reducing surfaces, power operated vehicles, seat lift mechanisms, or TENS units) are reimbursable when a written order is on file prior to delivery. In this case, report the code with modifier EY
	For DMEPOS providers, adhesive tape requires an appropriate modifier (AU, AV, AW or AX.). Adhesive tape is not reimbursable in an office setting
Nebulizers	Disposable large volume nebulizers are non-covered items
	Controlled inhalation medication delivery system is eligible for reimbursement when reported with the appropriate medication
	A pharmacy supply fee is reimbursable when reported with the appropriate medications
	A 90-day dispensing fee is reimbursable once per 90 days
	A 30-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 90-day pharmacy dispensing fee
	A 90-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 30-day pharmacy dispensing fee
	A 30-day pharmacy dispensing fee for inhalation medication(s) is reimbursable once per month
Non-contact normothermic wound warming devices	The non-contact wound warming device and accessories are not eligible for reimbursement as they are not considered safe nor effective
Osteogenesis stimulators	Only one type of osteogenesis (bone) stimulator is reimbursable for covered fractures
Ostomy supplies	Components of a more complete kit are included in the reimbursement for the kit

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
	Options and accessories that are part of a more complete ostomy product are included in the reimbursement for the ostomy appliance
Oxygen and oxygen equipment	Only one oxygen stationary system rental is reimbursable per month for those who qualify for coverage
	Portable oxygen rental is reimbursable once per month
	Frequently serviced items, such as oxygen systems, are reimbursable as a rental only
	Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement
	Oxygen contents reimbursement is included in the reimbursement for monthly rental of a stationary oxygen system
	Oxygen modifiers QE, QF and QG are recognized only when submitted with stationary oxygen rentals
	Oxygen is included in monthly oxygen system rental
Parenteral nutrition	Parental nutrition administration pumps are reimbursable once per month
	Homemix nutrient and component solutions are included in the reimbursement for the complete premix solution
	Parenteral nutrients solution is reimbursable at one unit per day
	One supply kit and one administration kit are reimbursable for each day that parenteral nutrition is administered
	Use of an IV pole and parenteral nutrition pump in an outpatient setting is included in the reimbursement for the underlying nutrition service
Patient lifts	An electric patient lift with seat and a multi-positional patient support system with integrated lift are non-covered items
	Patient lifts for the toilet and patient lifts that are free moving or fixed are non-covered items
	A sling is included in the reimbursement for a patient lift
Pneumatic compression devices	A segmental pneumatic appliance is eligible for reimbursement when reported with a segmental pneumatic compressor
	A non-segmental pneumatic compression appliance or segmental gradient pressure pneumatic appliance is eligible for reimbursement when reported with a non-segmental pneumatic compressor
Pressure reducing support surfaces	Alternating pressure pad and pressure pad alternating pump replacement are included in the reimbursement for an alternating pressure pad with pump
Prosthetic repair and replacement	Labor is included in the reimbursement for the replacement prosthesis and components
	Labor for prosthetic repair is included in the reimbursement for the prosthesis when it is reported within 90 days of a prosthesis

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – Commercial and Medicare Advantage	
Category	**Coding Edit**
Rentals	Rental durable medical equipment (DME) is considered for reimbursement once per month
	Capped rental equipment is reimbursable for a total of 13 months
	Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months
Repair	Repair of DME is included in the initial provision of DME
Transcutaneous electrical nerver stimulations (TENS)	The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee
Urological Supplies	A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device
	Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period
	Sterile intermittent catheters are reimbursable up to 600 times within 90 days
Walkers	Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement
Wheelchair options and accessories	Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option

*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record

The following claims coding edits apply to Health Net claims for the Medicare Advantage (MA) line of business:

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	
Category	**Coding Edit**
Blood glucose monitoring	Only one home blood glucose monitor is reimbursable per 12-month period of time
	A laser skin piercing device or replacement cartridge is reimbursed at the rate for the spring powered lancet and/or lancet replacements
	Urine test reagent strips, alcohol, peroxide, Betadine, and pHisohex are not separately reimbursed with glucose monitors and supplies
Diabetic shoes	Only one pair of therapeutic shoes for members with diabetes is reimbursable per calendar year
	Therapeutic shoe inserts or modifications for members with diabetes are reimbursable up to six units per calendar year
	Diabetic shoe inserts or modifications reported with non-diabetic footwear are not eligible for reimbursement
Enteral nutrition	Nasogastric tubes are reimbursable once a month
Eye prosthesis	An eye prosthesis is eligible for replacement once the useful lifetime of the prosthesis is reached (typically five years)
Lower limb prosthesis	Two test sockets are reimbursable per individual prosthesis
Nebulizers	Corrugated tubing for use with a large volume nebulizer is reimbursable once per two months
	An immersion heater for a nebulizer or durable bottle type nebulizer is reimbursable once per three years
	A non-disposable administration set used with a small volume nebulizer reimbursable once every six months
	The non-disposable administration set is reimbursable once every three months if used with a controlled dose inhalation delivery system
	Atropine, administered by nebulizer, is reimbursable up to 558 units every 3 months
	Bitolterol, administered by nebulizer, is reimbursable up to 1302 units every 3 months
	Glycopyrrolate, administered by nebulizer, is reimbursable up to 225 units every 3 months
	Isoetharine HCL, administered by nebulizer, is reimbursable up to 2790 units every 3 months
	Metaproteranol sulfate, administered by nebulizer, is reimbursable up to 740 units every 3 months
	Terbutaline sulfate, administered by nebulizer, is reimbursable up to 558 units every 3 months
	Isoproterenol HCL, administered by nebulizer, is reimbursable up to 1350 units every 3 months
Orthopedic footwear	Orthopedic footwear and the associated inserts or modifications are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*
	Custom-molded prosthetic shoes are not reimbursable when reported with partial foot prosthesis or other lower extremity prosthesis
Oxygen and oxygen	Oximeters and replacement probes are not covered because they do not meet the definition of DME

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	
Category	**Coding Edit**
equipment	Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement
	Oxygen is included in monthly oxygen system rental
Pneumatic compression devices	Only one type of pneumatic compressor (lymphedema pump) is eligible for reimbursement in the same month
Rental	Capped rental equipment is reimbursable for a total of 13 months
	Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months
Replacement	Durable medical equipment is eligible for replacement after its useful lifetime has been reached (typically a period of 5 years).
Transcutaneous electrical nerver stimulations (TENS)	The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee
Urological supplies	Urinary catheter insertion trays are considered for reimbursement at the frequency of two per calendar month. An additional two foley catheters are considered for reimbursement in the same month
	Bedside urinary drainage bags are eligible for reimbursement at the frequency of two per month
	Adhesive tape used with ostomy or urological supplies is eligible for reimbursement up to 40 units per month
	A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device
	Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period
	Sterile intermittent catheters are reimbursable up to 600 times within 90 days
Walkers	When an enclosed walker with rear seat is provided, it is reimbursed at the rate of a standard walker
	Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement
Wheelchair options and accessories	Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option

*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record.

All claims submissions remain subject to Health Net's prior authorization requirements.

Health Net does not require documentation at the time of claim submission. In the event the claim is audited, documentation may be required.

Supporting Sources:

- DME MAC
- HCPCS Level II
- Medicare National Coverage Determinations Manual (NCD)

Perinatal Services BC
An agency of the Provincial Health Services Authority

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark "X" in the box next to the answer which comes closest to how you have felt in the **past 7 days**–not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - 0 ☐ As much as I always could
   - 1 ☐ Not quite so much now
   - 2 ☐ Definitely not so much now
   - 3 ☐ Not at all

2. I have looked forward with enjoyment to things
   - 0 ☐ As much as I ever did
   - 1 ☐ Rather less than I used to
   - 2 ☐ Definitely less than I used to
   - 3 ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, some of the time
   - 1 ☐ Not very often
   - 0 ☐ No, never

4. I have been anxious or worried for no good reason
   - 0 ☐ No, not at all
   - 1 ☐ Hardly ever
   - 2 ☐ Yes, sometimes
   - 3 ☐ Yes, very often

5. I have felt scared or panicky for no very good reason
   - 3 ☐ Yes, quite a lot
   - 2 ☐ Yes, sometimes
   - 1 ☐ No, not much
   - 0 ☐ No, not at all

6. Things have been getting on top of me
   - 3 ☐ Yes, most of the time I haven't been able to cope
   - 2 ☐ Yes, sometimes I haven't been coping as well as usual
   - 1 ☐ No, most of the time I have coped quite well
   - 0 ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, sometimes
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

8. I have felt sad or miserable
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

9. I have been so unhappy that I have been crying
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Only occasionally
   - 0 ☐ No, never

10. The thought of harming myself has occurred to me
    - 3 ☐ Yes, quite often
    - 2 ☐ Sometimes
    - 1 ☐ Hardly ever
    - 0 ☐ Never

Total Score ☐

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.

The Royal College of Psychiatrists 1987. From Cox, JL, Holden, JM, Sagovsky, R (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry. 150, 782–786. Reprinted with permission.

Provider Reporting

Data File Record Layouts

COMMERICAL (ACE)

File Name: ELIGIBILITY
Report Number: ACE_RPT_BRM_42

All records in this file are 512 bytes long. There are four record types: Header, Detail, COB, and the Trailer record. Data expressed in the "X" format is left justified and blank filled, data expressed in the "9" format is right-justified and zero filled.

Header Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"1" = Header record
Title	002-009	X(8)	"ELIG HDR"
Info Effective Date	010-017	X(8)	CCYYMMDD, effective date
Provider Type	018-018	X(1)	"M" = Medical Provider - "H" = Hospital Provider
Provider ID	019-022	X(4)	PPG, or Hospital Number
Provider Name	023-055	X(33)	PPG, or Hospital Name
Address	056-080	X(25)	PPG, or Hospital Address
City	081-097	X(17)	PPG, or Hospital City
State	098-099	X(2)	PPG, or Hospital State
Zip Code	100-108	X(9)	PPG, or Hospital Zip Code
Filler	109-512	X(404)	Blank Spaces (Not Used)

Detail Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"2" = Detail Record
Member's Last Name	002-018	X(17)	Member's Last Name
Member's First Name	019-028	X(10)	Member's First Name
Member's Middle Initial	029-029	X(1)	Member's Middle Initial
Person ID	030-038	X(9)	Person ID
Group ID	039-046	X(8)	Health Net Employer / Individual Group Number
Member Code	047-049	X(3)	A code that describes the member's sex and a member's relationship to the subscriber
Insight Indicator	050-050	X(1)	Y/N Member has Mental Health Benefits
Plan Code	051-054	X(4)	Medical Plan of the employer / individual group the member belongs to
Office Visit Co-pay	055-057	X(3)	Office Visit Co-pay
DME Benefit	058-060	X(3)	Durable Medical Equipment benefit Co-pay
ER Benefit	061-063	X(3)	Emergency Room Co-pay
COB ID	064-071	X(8)	Coordination of Benefits ID
Birth date	072-079	X(8)	CCYYMMDD, Member's birth date
Satellite Provider ID	080-083	X(4)	Used only for consolidated files. Displays site where member is enrolled
Physician ID	084-089	X(6)	If physician level report, Health Net assigned PCP number, otherwise will be PPG number
Provider Effective Date	090-097	X(8)	CCYYMMDD, the date member is effective with this medical group

Cancel Effective Date	098-105	X(8)	CCYYMMDD, the date member cancelled with this medical group
Product Code	106-109	X(4)	HMO=”HMO Medical”, SNN=”Silver Network”, etc.
Fund Type	110-110	X(1)	Claims Funding Type – R=Regular, S=Self, F=Flex
Rx Indicator	111-111	X(1)	Pharmacy Benefit Indicator - Y/N
PR_TY	112-112	X(1)	PR_TY
Member Address_50	113-162	X(50)	Member's full Address
Member City	163-179	X(17)	Member's City
Member State	180-181	X(2)	Member's State
Member Zip Code	182-190	X(9)	Member's Zip Code
Member Phone Number	191-200	X(10)	Member's Home Phone Number
Member Reference ID	201-209	X(9)	Member Reference ID
Spoken Language	210-212	X(3)	Member Preferred Spoken Language (ISO code)
Written Language	213-215	X(3)	Member Preferred Written Language (ISO code)
Race	216-218	X(3)	Member Race
Ethnicity	219-221	X(3)	Member ethnicity
APTC flag	222-222	X(1)	APTC flag
DLQ flag	223-223	X(1)	Delinquency flag
Dlq month indicator	224-224	X(1)	Delinquency month indicator
Dlq start date	225-232	X(8)	Delinquency start date
Dlq end date	233-240	X(8)	Delinquency end date
Tribal flag	241-241	X(1)	Tribal flag
Aid category	242-244	X(3)	Aid category
Aid code	245-246	X(2)	Aid code
Project code	247-249	X(3)	Project code
CIN number	250-258	X(9)	(Medi-Cal) Client Identification Number
Medi-Cal case id	259-272	X(14)	Medi-Cal case id
Medicare stat A	273-273	X(1)	Medicare stat A
Medicare Stat B	274-274	X(1)	Medicare Stat B
Medicare stat D	275-275	X(1)	Medicare stat D
SPD/Dual flag	276-276	X(1)	SPD/Dual flag
CCS Flag	277-278	X(2)	CCS Flag
PCP Name	279-308	X(30)	Member’s PCP Name
Redetermination date	309-316	X(8)	Annual Redetermination date
Med provider id	317-321	X(5)	Member’s medical provider id
Full payment date	322-329	X(8)	Full payment date
PCP Site id	330-337	X(8)	PCP’s site id
HCP Code	338-339	X(2)	HCP Code
RC Indicator	340-340	X(1)	Regional Center Indicator Value “Y” or “N”
RC name	341-390	X(50)	Regional Center name
Alternate Format	391-393	X(03)	Alternate Format
Member Suffix	394-396	X(03)	Member Suffix
Assignment Type	397-398	X(02)	C – Choice, PT – Provider Transfer, DF – Default Family Choice, DP – Default Prior Choice, D – Default Value
Filler	399-400	X(02)	Blank Spaces (Not Used)
OHC Policy ID	401-415	X(15)	Policy ID for Other Health Coverage
Filler	416-416	X(1)	Blank Space
OHC Effective Date	417-424	X(8)	Effective Date of Other Health Coverage
Filler	425-425	X(1)	Blank Space
OHC Expiration Date	426-433	X(8)	Expiration Date of Other Health Coverage
Filler	434-434	X(1)	Blank Space
OHC Code Curr Month	435-435	X(1)	Other Health Coverage Code from 834 file A - Pay and chase (applies to any carrier) C - Military benefits comprehensive

			E - Vision plans F - Medicare Part C health plan G - Medical parolee H - Multiple plans comprehensive I - Institutionalized K - Kaiser N - No OHC P - Preferred Provider Organization/Prepaid Health Plan/Health Maintenance Organization/Exclusive Provider Organization or not otherwise specified V - Any carrier other than the above (includes multiple coverage) W - Multiple plans non-comprehensive
Filler	436-441	X(6)	OHC Code in effect for previous month
Original Effective Date	442-449	X(8)	Original effective date with the health plan (reserved for future use)
Filler	450-450	X(1)	Blank Space
Department code	451-456	X(6)	Department code
Filler	457-512	X(56)	Blank Space (not used)

COB Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"3" = COB Record
COB Carrier id	002-009	X(8)	Table COB carrier id
COB Carrier Name	010-039	X(30)	COB Carrier Name
OHC_Address_1	040-064	X(25)	OHC_Address_1
OHC_Address_2	065-089	X(25)	OHC_Address_2
OHC_City	090-106	X(17)	OHC_City
OHC_State	107-108	X(02)	OHC_State
OHC_ZIP_Code	109-119	X(11)	OHC_ZIP Code
OHC_Carrier Phone 1	120-134	X(15)	OHC_Carrier_Phone 1
OHC_Carrier Phone 2	135-149	X(15)	OHC_Carrier_Phone 2
OHC_Carrier Phone 3	150-164	X(15)	OHC_Carrier_Phone 3
OHC_Remark 1	165-214	X(50)	OHC_Remark 1
OHC_Remark 2	215-264	X(50)	OHC_Remark 2
Filler	265-512	X(248)	Blank Spaces (Not Used)

Trailer Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"4" = Trailer Record
Title	002-009	X(8)	"ELIG SUM"
Total Members EOM	010-017	9(8)	Total Members as of month end
Total Members in Month	018-025	9(8)	Total members eligible at least one day of the month
Total member SPC	026-033	X(8)	Member SPC
Total member SP1	034-041	X(8)	Member SP1
Filler	042-512	X(471)	Blank Spaces (Not Used)

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net)
Quick Reference Guide

eviCore healthcare administers the utilization management program for all outpatient MRI/MRA, CT/CTA, PET imaging studies, nuclear cardiac imaging procedures, including single photon emission computed tomography (SPECT), and sleep studies for all HMO, CommunityCare HMO, EPO, PPO, and Medicare Advantage (MA) Direct Network/Fee-for-Service members.

Imaging procedures performed during an inpatient admission or emergency room visit are NOT included in this program.

All of the outpatient imaging services listed above will be evaluated based on the applicable terms of the health benefit plan (including, but not limited to, medical necessity) and require prior authorization by eviCore healthcare. Services will be authorized for covered imaging studies performed at a facility within the Health Net network.

eviCore healthcare will respond to requests for prior authorization within two business days once complete clinical information is received.

Prior Authorization Process

There are three ways to request prior authorization for an imaging procedure from eviCore healthcare:

1. **Internet**
   Complete the Internet-based submission form by logging on to the secure Web site at **www.evicore.com.**

2. **Telephone**
   Contact eviCore healthcare toll-free, 5:00 a.m. to 6:00 p.m. PST, Monday through Friday at **(888) 693-3211** and give all pertinent clinical information over the telephone. Outside of these normal business hours, you may call eviCore healthcare and leave a voice mail for a return call the next business day. When calling eviCore healthcare with a request for prior authorization, please have the following information available:
   - Member demographic information, including Health Net member ID and date of birth
   - Current diagnosis and clinical information, including treatment history, treatment plan and medications
   - Member's chart and previous imaging study results

3. **Fax**
   Complete the demographics box at the top of the fax form and **include the office notes/previous imaging reports** for the member and fax your request to eviCore healthcare at (888) 693-3210.

Coverage Authorizations

Your request for prior authorization will be processed **within two business days** after the receipt of all necessary information. Once coverage is approved, an authorization number will be faxed to the ordering physician and requested facility, and mailed to the member. Please note: eviCore healthcare will specifically approve both the facility to perform the imaging study and the CPT code or codes for the diagnostic imaging.

Coverage Denials
If a request for prior authorization is denied, an eviCore healthcare representative will call the ordering physician's office and verbally communicate the denial determination and the rationale for the denial. The ordering physician may request a reconsideration of the denial decision by either faxing additional information or discussing the denial determination with the eviCore healthcare physician reviewer. Written notification of the final determination will be faxed to the requesting physician and mailed to the member. The written notification will include information about the member appeal rights.

Peer Review
Referring physicians or radiologists may request a peer review discussion of a denial decision with one of MedSolutions' physician reviewers. To request a peer review, call eviCore healthcare at (888) 693-3211 during normal business hours of 5:00 a.m. to 6:00 p.m. PST, Monday through Friday.

Expedited Requests
If the referring physician believes a medical emergency is occurring, prior authorization is not required for diagnostic imaging studies performed on an outpatient, emergent basis. eviCore healthcare physician reviewers will retrospectively review the request and the clinical documentation supporting the nature of the medical emergency.

MEDICALLY URGENT: For those situations where advanced imaging is required on the same day due to a medically urgent condition, **call** eviCore healthcare at **(888) 693-3211** for prior authorization. Have the pertinent clinical office notes, the member's chart and previous imaging study results available for reference during your call. eviCore healthcare will render a decision within **four hours of receipt** of all necessary information. Please clearly indicate that the prior authorization request is for **medically urgent care**.

eviCore healthcare Web-Based Services
You may access eviCore healthcare online for day-to-day transactions and services. To reach eviCore healthcare online services please go to the Web site, **www.evicore.com**, select your professional group and follow the online instructions. Here you may sign up for access to a variety of eviCore healthcare services, including prior authorization guidelines. Please be sure to watch the Web site for news of future online initiatives.

Fax Forms
You can request additional copies of the fax form by accessing the eviCore healthcare Web site at **www.evicore.com** or by calling the eviCore healthcare Customer Service Department toll-free at **(888) 693-3211, option # 3.**

HEPATITIS B VACCINATION DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Signature of Employee Date

ICD-10-CM Codes for Abortion-Related Services

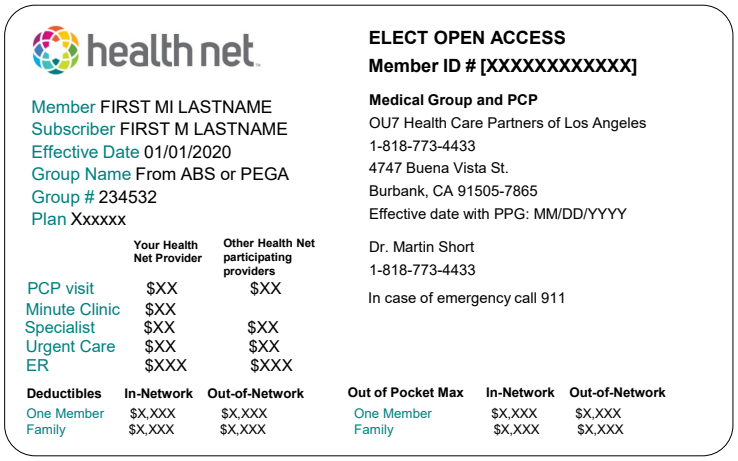
This list contains principal diagnosis codes for abortion and abortion-related services. If a code from this list is used as the principal diagnosis code, the services related to abortion will be processed by our claims processing systems at zero cost share to the member in accordance with Senate Bill 245 (the Abortion Accessibility Act). **Note: This list may not be all-inclusive and is subject to change.**

ICD-10 Codes	Descriptions
O00.00	Abdominal pregnancy without intrauterine pregnancy.
O00.01	Abdominal pregnancy with intrauterine pregnancy.
O00.101	Right tubal pregnancy without intrauterine pregnancy.
O00.102	Left tubal pregnancy without intrauterine pregnancy.
O00.109	Unspecified tubal pregnancy without intrauterine pregnancy.
O00.111	Right tubal pregnancy with intrauterine pregnancy.
O00.112	Left tubal pregnancy with intrauterine pregnancy.
O00.119	Unspecified tubal pregnancy with intrauterine pregnancy.
O00.201	Right ovarian pregnancy without intrauterine pregnancy.
O00.202	Left ovarian pregnancy without intrauterine pregnancy.
O00.209	Unspecified ovarian pregnancy without intrauterine pregnancy.
O00.211	Right ovarian pregnancy with intrauterine pregnancy.
O00.212	Left ovarian pregnancy with intrauterine pregnancy.
O00.219	Unspecified ovarian pregnancy with intrauterine pregnancy.
O00.80	Other ectopic pregnancy without intrauterine pregnancy.
O00.81	Other ectopic pregnancy with intrauterine pregnancy.
O00.90	Unspecified ectopic pregnancy without intrauterine pregnancy.
O00.91	Unspecified ectopic pregnancy with intrauterine pregnancy.
O01.1	Incomplete and partial hydatidiform mole.
O01.9	Hydatidiform mole, unspecified.
O02.1	Missed abortion.
O03.0	Genital tract and pelvic infection following incomplete spontaneous abortion.
O03.1	Delayed or excessive hemorrhage following incomplete spontaneous abortion.
O03.2	Embolism following incomplete spontaneous abortion.
O03.30	Unspecified complication following incomplete spontaneous abortion.
O03.32	Renal failure following incomplete spontaneous abortion.
O03.33	Metabolic disorder following incomplete spontaneous abortion.

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ICD-10 Codes	Descriptions
O03.34	Damage to pelvic organs following incomplete spontaneous abortion.
O03.35	Other venous complications following incomplete spontaneous abortion.
O03.36	Cardiac arrest following incomplete spontaneous abortion.
O03.37	Sepsis following incomplete spontaneous abortion.
O03.38	Urinary tract infection following incomplete spontaneous abortion.
O03.39	Incomplete spontaneous abortion with other complications.
O03.4	Incomplete spontaneous abortion without complication.
O03.5	Genital tract and pelvic infection following complete or unspecified spontaneous abortion.
O03.6	Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion.
O03.7	Embolism following complete or unspecified spontaneous abortion.
O03.80	Unspecified complication following complete or unspecified spontaneous abortion.
O03.81	Shock following complete or unspecified spontaneous abortion.
O03.82	Renal failure following complete or unspecified spontaneous abortion.
O03.83	Metabolic disorder following complete or unspecified spontaneous abortion.
O03.84	Damage to pelvic organs following complete or unspecified spontaneous abortion.
O03.85	Other venous complications following complete or unspecified spontaneous abortion.
O03.86	Cardiac arrest following complete or unspecified spontaneous abortion.
O03.87	Sepsis following complete or unspecified spontaneous abortion.
O03.88	Urinary tract infection following complete or unspecified spontaneous abortion.
O03.89	Complete or unspecified spontaneous abortion with other complications.
O03.9	Complete or unspecified spontaneous abortion without complication.
O04.5	Genital tract and pelvic infection following (induced) termination of pregnancy.
O04.6	Delayed or excessive hemorrhage following (induced) termination of pregnancy.
O04.7	Embolism following (induced) termination of pregnancy.
O04.80	(Induced) termination of pregnancy with unspecified complications.
O04.81	Shock following (induced) termination of pregnancy.
O04.82	Renal failure following (induced) termination of pregnancy.
O04.83	Metabolic disorder following (induced) termination of pregnancy.
O04.84	Damage to pelvic organs following (induced) termination of pregnancy.
O04.85	Other venous complications following (induced) termination of pregnancy.
O04.86	Cardiac arrest following (induced) termination of pregnancy.
O04.87	Sepsis following (induced) termination of pregnancy.
O04.88	Urinary tract infection following (induced) termination of pregnancy.

ICD-10 Codes	Descriptions
O04.89	(Induced) termination of pregnancy with other complications.
O07.0	Genital tract and pelvic infection following failed attempted termination of pregnancy.
O07.1	Delayed or excessive hemorrhage following failed attempted termination of pregnancy.
O07.2	Embolism following failed attempted termination of pregnancy.
O07.30	Failed attempted termination of pregnancy with unspecified complications.
O07.31	Shock following failed attempted termination of pregnancy.
O07.32	Renal failure following failed attempted termination of pregnancy.
O07.33	Metabolic disorder following failed attempted termination of pregnancy.
O07.34	Damage to pelvic organs following failed attempted termination of pregnancy.
O07.35	Other venous complications following failed attempted termination of pregnancy.
O07.36	Cardiac arrest following failed attempted termination of pregnancy.
O07.37	Sepsis following failed attempted termination of pregnancy.
O07.38	Urinary tract infection following failed attempted termination of pregnancy.
O07.39	Failed attempted termination of pregnancy with other complications.
O07.4	Failed attempted termination of pregnancy without complication.
O08.2	Embolism following ectopic and molar pregnancy.
O08.3	Shock following ectopic and molar pregnancy.
O08.4	Renal failure following ectopic and molar pregnancy.
O08.82	Sepsis following ectopic and molar pregnancy.
O08.83	Urinary tract infection following an ectopic and molar pregnancy.
O08.89	Other complications following an ectopic and molar pregnancy.
O20.0	Threatened abortion.
O20.8	Other hemorrhage in early pregnancy.
O20.9	Hemorrhage in early pregnancy, unspecified.
Q89.7	Multiple congenital malformations, not elsewhere classified.
Z33.2	Encounter for elective termination of pregnancy.
Z64.0	Problems related to unwanted pregnancy.





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Carry this ID Card with you at all times, and present it to your health care provider when getting the care you need.

See your plan documents for a description of your benefits.

Your Primary Care Physician

Your PCP oversees all your health care and provides referrals if specialty care is needed. Your health plan uses the Elect Open Access provider network. In order to be covered please make sure you use doctors, hospitals, etc. that are in the Elect Open Access provider network. If your situation is an emergency, call 911 or go to the nearest hospital or emergency care facility.

Prior Authorization Requirements

For a current listing of services subject to prior authorization before they are rendered, please refer to your Evidence of Coverage or Certificate of Insurance. You may also visit Health Net's website at www.healthnet.com or call the Customer Contact Center at 1-800-361-3366 (TTY: 711).

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You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, a treating specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through Teladoc will accrue toward your out-of-pocket maximum and deductible (if your plan has a deductible).By scheduling through Teladoc, you consent to receive services via telehealth through Teladoc. See your health plan coverage document for coverage information and for the definition of telehealth services. You have a right to access your medical records for services received through Teladoc. Unless you choose otherwise, any services provided through Teladoc shall be shared with your primary care provider.

IF AN EMERGENCY ARISES

If your situation is an emergency: Call 911 or go to the nearest Hospital or emergency care facility. If you are ill but unsure of the seriousness of your condition: You may call your Medical Group for assistance. In all cases, contact your Primary Care Physician/Medical Group as soon as possible to inform them about your condition.

PO Box 989883, West Sacramento, CA 95798-9883

ELECTRONIC SERVICE REQUESTED

90703

[MEMBERS NAME]
[MEMBERS MAILING ADDRESS]
[MEMBERS CITY STATEZIP + 4]

IFP Ambetter PPO network

Member ID# [R/Uxxxxxxxxx]

Effective date with PCP [MM/DD/YYYY]

Primary Care Physician Information

[PCP ID]
[PCP NAME]
[PCP Street Address]
[PCP City, State Zip]
[PCP Phone number]

Member name [FIRST MI LAST NAME]
Subscriber [FIRST LAST NAME]
Effective date [MM/DD/YYYY]
Plan [XXX] Including Metallic Level and Actuarial Number

Health Net of California, Inc.

(Copays may apply after deductible)
PCP Visit $XX **Specialist Visit** $XX **ER** $XXX **Urgent Care** $XX **Teladoc** $XX

Your Health Net ID card

Attached is your new Health Net member identification card. Please discard any old identification cards you may have from Health Net. If there is an error on this card, or you need to verify eligibility for benefits, please call us at 1-844-463-8188 (TTY: 711). Please see your Policy for full plan details.

Your primary care physician

You have selected or have been assigned the primary care physician (PCP) listed on your card. To receive the highest level of coverage, please make sure you choose providers (hospitals, doctors, etc.) that are in our Ambetter PPO provider network. You can see your PCP first, or you can go to any provider in the Ambetter PPO provider network. You don't need a referral. If your situation is an emergency, call 911 or go to the nearest hospital or emergency care facility. Want to change your PCP? You can:

- Go to www.myhealthnetca.com to find a doctor in the Ambetter PPO provider network.
- Call 1-844-463-8188(TTY: 711), Monday through Friday, 8:00 a.m. to 6:00 p.m

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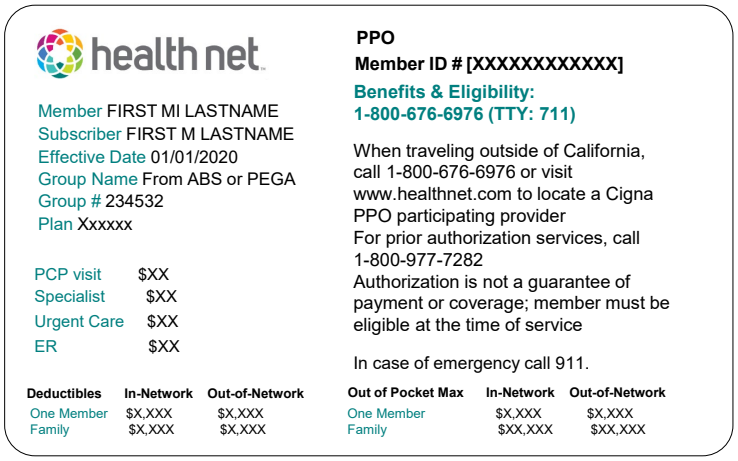
www.myhealthnetca.com
Customer Contact Center
Mental Health Benefits
24-hour Nurse Advice
Virtual Doctor Visits

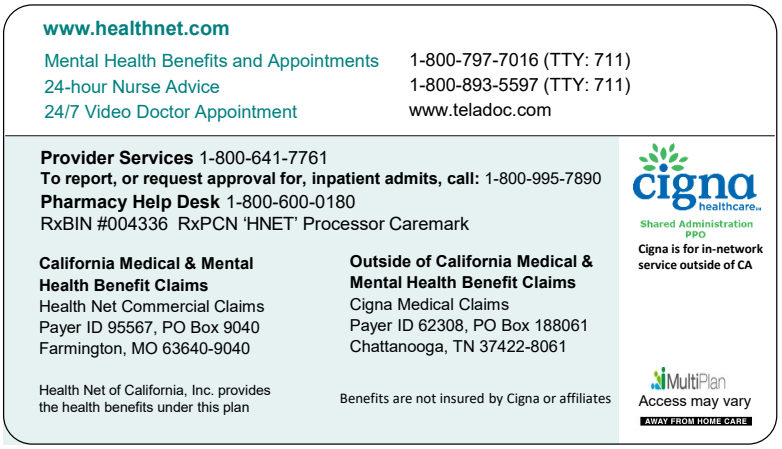
1-844-463-8188
1-800-977-7534
1-800-893-5597
www.Teladoc.com

Prior Authorization

You are responsible for obtaining prior authorization before certain services. Prior Authorization doesn't constitute eligibility for benefits and coverage, which are subject to eligibility rules and benefit limitations under the plan.
For prior authorization, call 1-800-977-7282

Pharmacy Help Desk 1-800-600-0180





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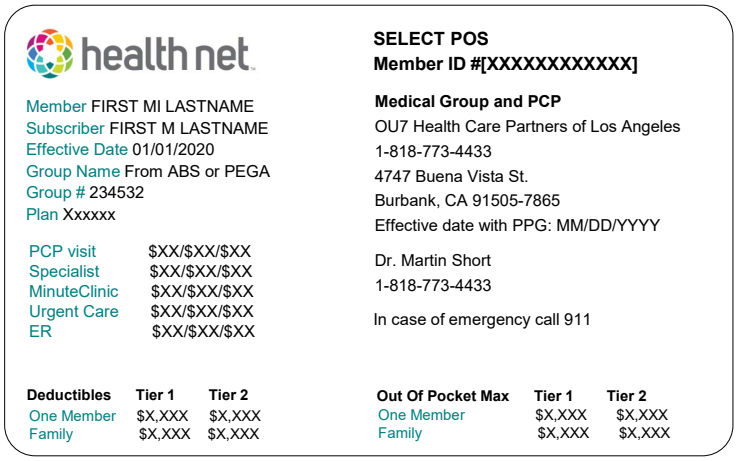
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health net

Member FIRST MI LASTNAME
Subscriber FIRST M LASTNAME
Effective Date 01/01/2020
Group Name From ABS or PEGA
Group # 234532
Plan Xxxxxx

PCP visit	$XX/$XX/$XX
Specialist	$XX/$XX/$XX
MinuteClinic	$XX/$XX/$XX
Urgent Care	$XX/$XX/$XX
ER	$XX/$XX/$XX

SELECT POS
Member ID #[XXXXXXXXXXXX]

Medical Group and PCP
OU7 Health Care Partners of Los Angeles
1-818-773-4433
4747 Buena Vista St.
Burbank, CA 91505-7865
Effective date with PPG: MM/DD/YYYY

Dr. Martin Short
1-818-773-4433

In case of emergency call 911

Deductibles	Tier 1	Tier 2
One Member	$X,XXX	$X,XXX
Family	$X,XXX	$X,XXX

Out Of Pocket Max	Tier 1	Tier 2
One Member	$X,XXX	$X,XXX
Family	$X,XXX	$X,XXX

www.healthnet.com

Member Services	1-800-676-6976 (TTY: 711)
Mental Health Benefits and Appointments	1-800-426-0030 (TTY: 711)
24-hour Nurse Advice Line	1-800-893-5597 (TTY: 711)
24/7 Video Doctor Appointment	www.teladoc.com

Provider Services 1-800-641-7761
To report, or request approval for, inpatient admits, call: 1-800-995-7890
Pharmacy Help Desk 1-800-600-0180
RxBIN #004336 RxPCN 'HNET' Processor Caremark

California Medical & Mental Health Benefit Claims
Health Net Commercial Claims
Payer ID 95567, PO Box 9040
Farmington, MO 63640-9040

Outside of California Medical & Mental Health Benefit Claims
Cigna Medical Claims
Payer ID 62308, PO Box 188061
Chattanooga, TN 37422-8061

Health Net of California, Inc. provides the health benefits under this plan

Benefits are not insured by Cigna or affiliates

cigna healthcare
Shared Administration PPO

MultiPlan
Access may vary

AWAY FROM HOME CARE

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Examples of IFP member eligibility status displayed on the secure provider portal

The image below shows examples of how member status displays when verifying eligibility for Individual and Family Plan (IFP) members on the secure provider portal. Status displays as “eligible” (thumbs up icon), “ineligible,” “delinquent,” or “suspended”:



Provider Communications

HEALTH INDUSTRY COLLABORATION EFFORT

HICE

Simplifying Healthcare Administration

Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

On behalf of the ICE Cultural and Linguistic Workgroup,

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Health Net of California, Inc.
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Cigna Language Assistance Services Manager

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SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact



Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is

1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

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[1] Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations**- *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion**- *asks about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identifies your patient's language needs including health literacy levels. Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment –** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as "*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*"

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

✓ Use simple words and avoid jargon. ✓ Never use acronyms. ✓ Avoid technical language (if possible). ✓ Repeat important information – a patient's logic may be different from yours. ✓ Ask patients to repeat back to you important information. ✓ Ask open-ended questions. ✓ Use medically trained interpreters familiar with cultural nuances.	✓ Give information in small chunks. ✓ Articulate words. ✓ "Read" written instructions out load. ✓ Speak slowly (don't shout). ✓ Use body language to support what you are saying. ✓ Draw pictures, use posters, models or physical demonstrations. ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

Use **Ask Me 3®**[2]. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?



Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.



INTERVIEW QUESTIONS

Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.*

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.*

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?*

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.*

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

EFFECTIVE COMMUNICATION

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

AUXILIARY AIDS AND SERVICES

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key.
For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

COMPANIONS

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the ADA, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	**These are some options we can provide for you…..**
Am blind or have vision impairments that keep me from reading	- Large print materials - Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped https://www.loc.gov/nls/pdf/application.pdf - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older- People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:
The KEY to Patient Engagement

Where do I start?
Check out the Q&A below to learn more...



Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:
- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

Go: *pull it all together, implement, evaluate, plan for the future*

What language service needs should I begin to identify?

Keep it simple and write down:
- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!
- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!
- Review resources and identify those most useful for your office

Go!
- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies. and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit http://ddtp.cpuc.ca.gov/homepage.aspx

Teletype Device

Relay Operator

Cell or Landline Phone



SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B



RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP member over the phone



- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent
- answers to your questions
- Member may have trouble communicating in English or you may have a
- very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

"*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

OR

"*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

"*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak…." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

TIPS FOR WORKING WITH INTERPRETERS

TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

When the interpreter comes onto the line let the interpreter know the following: **

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.**

ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **



- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
  Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

1) Identify the languages spoken by your patients, and
2) Identify the language services available to meet these needs

For example:

Language spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in person interpreter

Identify the language capability of your staff (See Employee Language Skills Self-Assessment)
• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency
• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. ***IF you use a minor, document the reason a minor was used.***

<u>Identify services available</u> do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry Collaboration Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic العربية
أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Armenian Հայերեն
Նշեք, թե որ լեզվով եք խոսում: Թարգմանիչ կկանչենք: Թարգմանչի ծառայությունները տրամադրվում են անվճար:

Bengali বাংলা
আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বোভাষীকে ডাকা হবে। দ্বোভাষী আপনি নিখরচায় পাবেন।

Cambodian (Khmer) ខ្មែរ (កម្ពុជា)
សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។

Chinese (Cantonese) 廣東話
請指認您的語言，以便為您提供免費的口譯服務。

Chinese (Mandarin) 普通话
请指认您的语言，以便为您提供免费的口译服务。

Farsi (Persian) فارسي
زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

Greek Ελληνικά
Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.

Hindi हिंदी
अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।

Hmong Hmoob
Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Japanese 日本語
あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean 한국어
귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.

Portuguese Português
Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi ਪੰਜਾਬੀ
ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Russian Русский
Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Samoan Fa`asamoa
Fa`asino lau gagana. Ole a vala`au se fa`amatala`upu. Ua saunia se fa`amatala`upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Español
Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai ไทย
ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย

Tongan Tongan Lea Faka-Tonga
Tuhu`i mai ho`o lea fakafonua. `E ui ha fakatonulea. `Oki ta`etotongi kia `a e fakatonulea.

Urdu اردو
اپنی زبان پر اشارہ کریں- ایک ترجمان کو بلاجائے گا- ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا-

Vietnamese Tiếng Việt
Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

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COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中文	*Chinese*	歡迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieâït	*Vietnamese*	Phòng vệ sinh
中文	*Chinese*	洗手間

Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**

Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Cl
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Courtesy statements	***Frases de cortesía***	***Từ ngữ lịch sự***	
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Patient may say….	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	病
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

Patient may say…	*El paciente puede decir…*	*Bệnh nhân có thể nói...*	*病人可能會說...*
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？

Point to a sentence **Señale una frase** **Xin chỉ vào câu** **指向句子**

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員可能會問或說。。。*
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	
Point to a sentence	Señale una frase	Xin chỉ vào câu	

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員*
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現*

Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**

Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kr
Point to a sentence	**Señale una frase**	**Lonje dwèt ou s**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Ko***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an ka*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè dokè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	ske mwen ka gen yon entèprèt?

Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab di oubyen mande...**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka ȅ pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon entȅprȅt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon entȅprȅt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Krey
Point to a sentence	Señale una frase	Lonje dwèt ou sou
Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **po**
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou
Now, fill out these forms, please	*Ahora, por favor conteste estas formas.*	*Kounye a, ekri enfimasyon yo ma*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.
Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ **Department/Job Title:** _____

_____

Work Days: **Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun** **Work Hours (Please Specify):** _____

_____

Directions: (1) List any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language

Language	**Dialect, region, or country**	**Fluency: see attached key (Circle)**			**I would like to use my language skills to speak with patients (Circle)**	**I would like to use my reading language skills to communicate with patients (Circle)**	**I would like to use my language skills to write patient communications (Circle)**
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?



SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: http://minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities…

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit https://www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website https://www.thinkculturalhealth.hhs.gov , sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):



- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, http://minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, http://minorityhealth.hhs.gov
- Think Cultural Health, https://www.thinkculturalhealth.hhs.gov

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
Confidentiality Preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020[2], LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.



Visit glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit glaad.org for additional resources on how to fairly and accurately report on transgender people

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- **GLMA cultural competence webinar series**
- **Providing Enhanced Resources Cultural Competency Training**
- **LGBT Health Resources**
- **Equal Employment Opportunity Commission** for your local EEOC field office
- **Creating an LGBT Friendly Practice**
- **LGBT Training Curricula for Behavioral Health and Primary Care Practitioners**
- **Preventing Discrimination**
- **Bullying Policies & Laws**

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.



- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.



- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
    - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
    - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
    - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.



- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.



EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand,	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
Beliefs About Drug Addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

		what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **Note: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.1

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Other federal and state legislation protecting the right to "equal care" outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued "Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:



5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.
The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity
  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier

an obstacle, impediment, obstruction, boundary, or separation.

Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication

the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

Disability

any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity

an avoidable and unfair difference in health status between segments of the population.

Health Literacy

the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation
: In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
: one who translates orally for parties conversing in different languages.

Language
: the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
: is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
: Anything intended to aid memory.

Race
: the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
: an asset valuable commodity or service.

Service
: help or assistance.

Speech
: the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
: a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
: a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
: an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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Guidance to Comply with New Interpreter Quality Standards
Requirements on the use of Bilingual/Multilingual Staff as Interpreters

Summary of Requirements and Documentation		
Requirement	**Potential Evidence**	**Provider Office to Note Documentation of Qualification**
Office has a documented policy to offer interpreter support to LEP patients	☐ Local office written policy; or ☐ Local office policy that defers and adheres to the policy distributed by medical group Note: Policy includes documentation of patient language needs in medical record	Written policy available for viewing by an auditor Policy title:
Adheres to generally accepted interpreter ethics principles, including client confidentiality	Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at: http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf	Signed attestations are available. ☐ Yes ☐ No
Has *demonstrated* proficiency in speaking and understanding both spoken English and at least one other spoken language	☐ Formal assessment of proficiency; or ☐ Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology	☐ Formal assessment of proficiency; or Annual performance evaluations document ☐ Ability to interpret effectively, ☐ Ability to interpret accurately, ☐ Ability to interpret impartially, ☐ Ability to interpret receptively and expressly, ☐ Ability to interpret to and from English and another language using any **necessary specialized vocabulary terminology and phraseology** Note: see NCIHC Interpreter Code of Ethics for description of above.	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D. **http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf**		

Language Proficiency Assessment Resources

The bilingual assessment vendors included on this list are suggestions that providers might consider if they choose to use a bilingual assessment vendor to help ensure that they are using qualified bilingual staff to provide patient care, as these organizations have self-attested that they meet the required criteria. However, that should not be considered an endorsement for any language service vendor by ICE. The ICE C&L Team has not in the past and does not now endorse any language service vendors.

Language Proficiency Assessment Resources						
		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Berkeley Language Institute (BLI) Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).	http://www.berkeleylanguageinstitute.com/index.html 1-510-655-9469 Marci Valdivieso marci@berkeleylanguageinstitute.com	**8 languages offered**: Arabic, Chinese (Mandarin, Cantonese, and Taishanese/ Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese	Yes	• Professional language assessments for interpreters, translators, & bilingual speakers • Language Proficiency Oral Assessment – ideal for current & pre-employment bilingual employees • Language Proficiency Written Assessment • Medical Staff Oral Assessment • Healthcare Interpreter Assessments	Evaluators are experienced linguists that have: • At least five years interpreter & translator experience • Have shown an aptitude to be language evaluators. • They are generally certified by/with the National Board or CCHI if the language pair is an option, or • They are otherwise assessed and trained prior to being given evaluation assignments	Cost will vary depending on language pair and type of assessment $115 - $190/ person
Culture Advantage Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.	https://cultureadvantage.org/ 1-316-217-0198 Marlene Obermeyer, MA, RN director@cultureadvantage.org	**10 languages offered**: Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese	Yes All medical specialties offered in the professional program	• Bilingual Staff Medical Interpreting Skills Assessment (MISA) • Specialty-specific Medical Interpreting Skills Assessment	• Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair	Cost will vary $200 /MISA $250 - $950 for Online Courses
ISI Language Solutions ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations.	https://isilanguagesolutions.com/industries/healthcare/ 1-818-753-9181 John Lopez john@isitrans.com Christina Xu Christina@isitrans.com	**22 languages offered**: Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese	No	• Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole ○ Language Proficiency Assessment ○ Building Cultural Competency Workshop ○ Medical Terminology Workshop ○ Medical Interpreting Ethics and Protocol Workshop	Professional Linguists • Certification or Accreditation from American Translators Association (ATA) or equivalent organization • Degree in Translation or foreign equivalent • Subject-Matter expertise in the field of Life Sciences • Extensive experience in translation and linguistics	Must contact for costs Cost example: • Flat rate/ test - $80

To report any updates to this document, i.e., an organization that should no longer be included, or an organization that meets the criteria and should be included on this document, please contact: Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Language Line Academy (LLA) Our professional testing and training ensures the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.	https://www.langualeline.com/ 1-844-552-8378 Ana Catalina Arguedas Fernández lla@languageline.com	**1 language offered**: Spanish	Yes Pediatrics Mental Health OB/Gyn Ophthalmology Gastroenterology Oncology Cardiology Pharmacy	• Healthcare Bilingual Fluency assessment for clinicians and medical staff • Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour • Interpreter Readiness Assessment • Interpreter Skills Test	LLA testers have a variety of qualifications, including: • M.A., Translation & Interpretation • Years of medical interpreting experience • External interpreter certification credentials	Cost will vary $145 - $160/ test Volume discounts available
Language Testing International (LTI) In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests.	https://www.languagetesting.com/ 1-800-486-8444 Marketing/ Scheduling Team Diane ext. 123 Dina ext. 127 info@languagetesting.com	**100+ languages offered**, most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish View complete list of languages online	Offers general testing/ proficiency assessments Does not specifically assess proficiency for healthcare interpretation or translation services	• Oral Proficiency Interview 15 – 30 minute telephonic interview • Oral Proficiency Interview – Computer 20 – 40 minute on-demand, internet or phone-delivered proficiency test • Writing Proficiency Test via the web 20 – 80 minutes • Listening Proficiency Test 50 – 125 minutes • Reading Proficiency Test 50 – 125 minutes	LTI strictly uses • Certified ACTFL testers and raters Ensuring quality and validity of tests	Contact for costs Package options available for some languages Cost examples: • $100 - $200/ person for phone survey • $159 for web based proctoring
MasterWord For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.	https://www.masterword.com/ 1-866-716-4999 masterword@masterword.com	**250+ languages offered** for interpreting and translation **Contact for languages offered for proficiency assessments**	Not specified Offers On Demand training & Webinars for Healthcare, includes: • Maternal Fetal Medicine • Cardiology • Mental Health • Oncology • Emergency	• Language Proficiency Assessment: 60 minutes Contact for languages • Health Care Interpreter Assessment (HCIA®): 32 min. / 45 min. –oral / written Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.	Assessments based on formats of CCHI & NBCMI national certification exams	On Demand Assessments: $105 - $155

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Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).



We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials:
email Ivy Diaz at ivy.diaz@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

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25-689/BKT1617350EH02w (6/25)

INPATIENT CALIFORNIA HEALTH NET COMMERCIAL PRIOR AUTHORIZATION

Complete and **Fax: 844-694-9165**
Behavioral Health Requests **Fax: 855-663-2244**

HMO

POS

PPO

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

***Indicates Required Field**

MEMBER INFORMATION

Last Name, First

*Date of Birth

*Member ID

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider *Address*

*Fax

City, State, ZIP

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing Provider Contact Name

*Servicing NPI

*Servicing TIN

Phone

Servicing Provider/Facility Name Address

Fax

City, State, ZIP

AUTHORIZATION REQUEST

***Primary** Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

***Start Date** OR Admission Date

(MMDDYYYY)

*Diagnosis Code

(ICD-10)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

(MMDDYYYY)

Additional Diagnosis Code

(ICD-10)

*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

Delivery
779 C-Section Delivery
720 Vaginal Delivery

Inpatient Rehab
427 Rehab

Transplant
992 Transplant

Miscellaneous
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
490 Boarder Baby
300 Neonate

Miscellaneous
121 Hospice Inpatient
492 Sub Acute

Behavioral Health
528 BH Chemical Substance Abuse
529 BH Psychiatric Admission

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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XD-PAF-1653

No-Cost Interpreter Services Available 24/7 for Your Patients

YOU AND YOUR PATIENTS CAN ACCESS NO-COST INTERPRETER SERVICES IN OVER 150 LANGUAGES. CALL 800-675-6110.



Access an interpreter

1. Call 800-675-6110.
2. Press “0” for English.
3. Press “2” for Provider.
4. Press “1” for a direct transfer to an interpreter.

Hours: Monday through Friday, 8 a.m. to 6 p.m., Pacific time for assistance. After hours, select the member option.

In-person or video interpreter requests

- Request at least 5 business days in advance during regular business hours.
- Allow 10 business days for sign language interpreter requests.

Ask for no-cost interpreter services to help you effectively communicate with your patients.

When asking for an interpreter, tell us:

- The patient’s Plan identification (ID) number
- The appointment date, time and place (or video link and password)
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

For office use only. Do NOT post in a patient area.

Phone numbers listed here are for provider use only. Patients may contact the number listed on the back of their ID card for Member Services.

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26-932 (8/26)

wellcare By health net

Akorbi
PEOPLE ■ TECHNOLOGY ■ LANGUAGE

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

Lao (ພາສາລາວ)
ທ່ານເວົ້າພາສາບໍ? ພວກເຮົາຈະຈັດກຽມນາຍແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Mandarin (中文)
您講中文嗎? 我們將免費為您提供翻譯。

Mixteco
¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

Navajo (Diné bizaad)
Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

Portuguese (Português)
Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

Punjabi (ਪੰਜਾਬੀ)
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

Russian (Русский)
Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

Spanish (Español)
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

Tagalog
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

Thai (ภาษาไทย)
คุณพูดภาษาไทยใช่หรือไม่
เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

Vietnamese (Tiếng Việt)
Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

American Sign Language (ASL)

Please call Provider Services using the number on the member's ID card or contact 800-929-9224.

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ADULT HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. _____

Age: _____ Sex: Male Female MR# _____

Immunizations current: Yes No
(See Immunization list below)

TB Risk: Yes No
(Every Periodic Physical Examination)

Advanced Directive discussed: Yes No

Date Discussed: _____

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	18 yrs. and older	Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.			
IHEBA/"Staying Healthy"	18 yrs and Older	Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years.	Record on Staying Healthy Form.		
Check-Up Visit	18 yrs. and older	Every 1-3 years			
	Age > 65	Annually			
Cholesterol	Male, 35 yrs. and older	Every 5 years			
	Female, 45 yrs. and older	Every 5 years			
Diabetes Mellitus Screening	As risk factors indicate	PRN			
Urinalysis	65 yrs. and older	PRN			
Breast Exam	Age > 40 yrs.	Annually			
Mammography	50-74 yrs.	Every 2 years			
Pelvic Exam	19-39 yrs.	Every 1-3 yrs.			
	40 and older	Annually			
Pap Smear	Onset of sexual activity or 21-65 yrs.	Every 1 to 3 yrs. At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.			
Chlamydia	< age 25, all sexually active non-pregnant women > age 25, as risk factors indicate				
Bone Density	65 yrs. and older	At least once			
Vitamin D Deficiency	65 yrs. and older	At clinician's discretion			
TSH Screening	40 yrs. and older	Every 5 years			
Fecal Occult Blood	50-75 yrs., then at clinician's discretion	Annually			
Sigmoidoscopy	50 and older	3-5 yrs.			
	High Risk	PRN			
Colonoscopy	50 and older	Every 10 years			
Prostate Exam	Physician discretion and as clinically indicated	PRN			
PSA	50 and older or as clinically indicated	PRN			
Adult Immunizations					
Tetanus-Diptheria-Pertussis(Tdap) Tetanus-Diphtheria (Td)	18 yrs. and older 18 yrs. and older	1 dose only Every 10 yrs.			
HPV	Females, 18-26 yrs. (HPV2 or HPV4) Males, 18-26 yrs (HPV 4)	3 doses			
Varicella	18 yrs. and older	2 doses if no evidence of immunity			
Zoster	60 yrs. and older	1 dose			
MMR	Born 1957 or after Born before 1957	1-2 doses unless immunity documented Considered immune, unless documentation of immunity required			
Influenza	18 yrs. and older	Annually			
Pneumococcal	18 yrs. and older	1-2 doses, when clinically indicated			
Hepatitis A	18 yrs. and older	2 doses			
Hepatitis B	18 yrs. and older	3 doses			
Meningococcal	18 yrs. and older	1 dose, 2nd dose if high risk			

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
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Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

LAST NAME: **FIRST NAME:** **MRN#**

PLACE OF SCREENING: **CIRCLE ONE:** ANSI - #____ ISO - #____

AUDIOMETER: **SCORING:** Child responds at 25 dB: Child does not respond at 25 dB: ☐

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To:

Signature & Title of Person Performing Test

HISTORIA MEDICA Y EXAMEN FISICO

MRN # _____

NOMBRE:	ESTADO CIVIL: ❑· S ❑ C ❑ V ❑ D ❑ SEP.	FECHA:
FECHA DE NACIMIENTO:	TEL (CASA):	TEL (TRABAJO):
OCUPACION/EMPLEADOR	Nº del Seg. Soc.:	Nº del SEGURO:

HISTORIA MEDICA FAMILIAR

SI ALGUN PARIENTE SANGUINEO HA TENIDO CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES, PONGA UN CIRCULO ALREDEDOR DEL NUMERO E INDIQUE QUE PARIENTE.

1) ALCOHOLISMO
2) ANEMIA
3) ASMA
4) ARTRITIS
5) SANGRA FACILMENTE
6) CANCER
7) DIABETES
8) EPILEPSIA
9) GLAUCOMA
10) ASMA DEL HENO
11) ENFERMEDAD CARDIACA
12) HIPERTENSION
13) ENFERMEDAD RENAL
14) ENFERMEDAD MENTAL
15) MIGRAÑA
16) OSTEOPOROSIS
17) APOPLEJIA
18) TIROIDES
19)
20)

INTERNACIONES EN HOSPITALES

(sin incluir embarazos)

AÑO — ENFERMEDAD U OPERACION

ALERGIAS

Pasado:

Presente:

ANOTE TODOS LOS MEDICAMENTOS QUE TOMA AHORA: (incluso los que se venden sin receta médica)

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

VACUNA (Fecha de la última)	PRUEBA / EXAMEN (Fecha del último)
Tétano / Difteria	Colesterol
Influenza	Dental
Neumocócica	Vista
Hepatitis	Oído
	Rectal / Excremento
	Sigmoidoscopía
	Prueba cutánea de tuberculosis

HISTORIA MEDICA

Marque con una palomita (✓) e indique la edad en la que tuvo cualquiera de los siguientes síntomas o enfermedades. MARQUE con una equis (X) los problemas actuales.

PROBLEMAS PRINCIPALES 1) _____ 2) _____ 3) _____

❑ Oído disminuido
❑ Zumbido en el oído
❑ Infecciones de oído - *frecuentes*
❑ Mareos
❑ Falla de la vista ❑ Dolor del ojo
❑ Visión doble o borrosa
❑ Infecciones del ojo - *frecuentes*
❑ Sangrado de la nariz - *recurrentes*
❑ Problema del seno
❑ Dolores de garganta - *frecuentes*
❑ Asma del heno / Alergias
❑ Ronquera - *prolongada*
❑ Neumonía / Pleuresía
❑ Bronquitis / Tos crónica
❑ Asma / Jadeo
Falta de aliento:
❑ Haciendo esfuerzo
❑ Estando acostado
❑ Dolor del pecho
❑ Presión sanguínea alta
❑ Soplo cardíaco
❑ Pulso irregular
❑ Palpitaciones
❑ Tobillos hinchados
❑ Desmayos
❑ Dolor de pierna - *caminando*
❑ Venas varicosas / Flebitis
❑ Pérdida del apetito - *reciente*
❑ Dificultad para tragar

❑ Indigestión o acidez estomacal
❑ Ulceras pépticas
❑ Dolor abdominal - *crónico*
❑ Problema de vesícula biliar
❑ Ictericia / Hepatitis
❑ Cambio de hábitos de evacuación intestinal
❑ Diarrea ❑ Estreñimiento
❑ Diverticulosis
❑ Enfermedad de Crohn / Colitis
❑ Excrementos sanguinolentos o alquitranados
❑ Hemorroides
❑ Hernia
❑ Infecciones urinarias - frecuentes
❑ Sangre en la orina
❑ Emisión de orina ❑ Durante la noche más de dos veces
❑ Dolorosa
❑ Pérdida del control
❑ Disminución de la Fuerza/Flujo
❑ Cálculos renales
❑ Enfermedad venérea
❑ Derrame uretral
❑ Fatiga crónica
❑ Pérdida de peso - *reciente*
❑ Anemia
❑ Se magulla fácilmente

❑ Cancer
❑ Diabetes
❑ Enfermedad de tiroides
❑ Convulsiones / Ataques epilépticos
❑ Apoplejía
❑ Temblor / Manos temblantes
❑ Debilidad muscular
❑ Adormecimiento / Sensaciones de hormigueo
❑ Dolores de cabeza - *frecuentes*
❑ Artritis / Reumatismo
❑ Dolor de Espalda - *recurrente*
❑ Fracturas óseas / Lesión de articulaciones
❑ Gota
❑ Osteoporosis
❑ Dolor de pie
❑ Pies fríos y adormecidos
❑ Sarpullido
❑ Ronchas
❑ Psoriasis
❑ Eczema
❑ Sueño - *dificultad*
❑ Nerviosismo
❑ Depresión
❑ Pérdida de la memoria
❑ Mal humor - *excesivo*
❑ Fobias

❑ Enfermedad mental
❑ Varicela
❑ Poliomielitis
❑ Paperas
❑ Sarampión
❑ Rubéola
❑ Fiebre reumática
❑ Escarlatina
❑ Tuberculosis
❑ Herpes
❑ Contacto con sangre o fluidos corporales
❑ Alcohol _____ onzas por semana
❑ Fuma _____ cig. por día
Número de años_____
❑ Café / Té
Nº de tazas por día _____
❑ Directivas con adelanto

HOMBRES - Favor de completar
Fecha del último examen de próstata

❑ Normal ❑ Anormal
Fecha de la última PSA _____

MUJERES - Favor de completar
Flujo Menstrual:
❑ Reg. ❑ Irreg.
❑ Dolor / Cólico
Días de flujo _____
Duraciones del ciclo _____
Fecha del último período _____
❑ Dolor / Sangramiento durante o después del coito
Número de:
Embarazos _____
Abortos provocados _____
Abortos espontáneos _____
Nacimientos con vida _____
Método de control de la natalidad _____
Píldora de control de la natalidad (nombre) _____
❑ Calores súbitos / Menopausia
Fecha del último examen pélvico _____
Fecha de la última prueba de Papanicolaou _____
❑ Normal ❑ Anormal

Fecha del último examen de senos _____
Fecha del último mamograma ____
❑ Normal ❑ Anormal

SINOPSIS **PARA USO DE OFICINA SOLAMENTE:**

Directivas Anticipadas: ❑ Si ❑ No Educativo de Directivas Anticipadas: ❑ Cuestionario "Mantengase Saludable" Fecha:_____

Firma: Dr./Dra.

MEDICATION AND SUMMARY CHART MRN

NAME: **DATE OF BIRTH:** **HT:** **WT:**

ALLERGIES

Pharmacy Name & Telephone #

Patient's (home) Telephone #s: (work)

PROBLEM # START DATE	MEDICATION DOSAGE/FREQ.	REFILL DATES *(record any changes in dosage or frequency)*				STOP DATE OR CONTINUED

CHRONIC PROBLEM LIST

	Date Resolved
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Signature Page

(Please post on left-hand side of each Medical Record)

Please Write Signature as Entries are Typically Signed	Print Name in Full (First Name, Last Name, Title)

Medical / Behavioral CoManagement Referral Form

Date of Referral: E-Mail:	Referred by: Referrer's phone #:	
Patient Name: Patient Contact Information: Patient Expecting MHN's Call: Special Instructions:	Patient ID #:	DOB:
Current Provider / Primary Care Physician / Specialist Name: Telephone #: Office Contact Name:	Fax #: Telephone #:	
If Inpatient, complete the following: Service Requested: Facility Name: Facility Contact Name:	Diagnosis: Facility City/State: Telephone #:	

Requesting:

- Outbound call to member
- Outbound call to provider/facility
- Psych consult on med bed/nursing home/SNF
- Consultation with Referring Case Manager
- Other / Unknown

Referral to MHN (Behavioral Health Triggers)

- Eating Disorder admitted to medical unit
- Catastrophic Illness requiring behavioral health support
- Behavioral health follow-up upon discharge from medical admission
- Complicated detox requiring medical admission
- Difficult placement due to behavioral health problems
- Medical admission with planned or actual transfer to psychiatric unit
- Referrals for post discharge substance abuse treatment while still at medical facility
- Pain management with substance abuse issues
- Frequent ER visits for behavioral health diagnoses or medical reason impacted by behavioral health issues
- Dementia with acute exacerbation of behavioral / psychological symptoms
- Autism Spectrum Disorders with behavioral health needs
- Member screened positive on depression screening
- Other

MHN referral to Health Net (Medical Triggers)

- Lack of an established or an ineffective treatment plan
- Over/under/inappropriate utilization of services
- Discharged/discharging from behavioral inpatient with medical needs
- Medical condition needing follow-up
- Lack of education of disease course/process
- Non-adherence to treatment/medications, missed appointments
- Compromised patient safety
- Lack of family/social support
- Lack of financial resources to meet health needs
- Exhaustion of medical benefits
- Member requesting medical Case Manager
- Autism Spectrum Disorders (OT, PT, ST requests)
- Pharmacological question
- Other

Additional Information:

Contact Information for Referrals to MHN

- Email completed form to MHN at: MHN.Case.Management.Referrals@healthnet.com
  OR
- For HNCA members, fax completed form to MHN at (855) 703-3268
- For HNAZ & HNOR/WA members, fax completed form to MHN at (855) 661-0077
- Urgent/Emergent requests, also call (888) 426-0030

Contact Information for MHN Referrals to Health Net

For Health Net / MHN Use Only

- Email completed form to Case Management Referrals/GRP/HNCA/HNT
- Urgent/Emergent Requests, also call (888) 732-2730

Created by Sandra Morrison
Manager, Healthnet Care Management 12/2013
Rev 01/28/14 by L. Tulumello/T. Wasserman

ALERE LEVEL OF CARE CRITERIA

NICU – Revenue Code 174

1. Ventilator/Intubated
2. Extracorporeal Membrane Oxygenation (ECMO) / Nitric Oxide (NO)
3. Any nasal flow delivered at > 2 lpm. For infants < 1kg, any nasal flow delivered at > 1 lpm.
4. Chest Tube
5. Exchange transfusion, dialysis
6. IV bolus or continuous drip therapy for severe physiologic/metabolic instability
7. Apnea/bradycardia > 10 day all requiring tactile stimulation or any episodes requiring Positive Pressure Ventilation (PPV)
8. Unstable vital signs requiring therapy or conditions requiring frequent Vital Signs. (Medical Director consultation required prior to assignment).

TRANSITIONAL – Revenue Code 173

1. Isolette/Warmer for thermoregulation
2. Static ↓ oxygen requirement via nasal cannula (less than or equal to 2 lpm or hood
3. Enteral nutrition delivered by methods other than p.o.
4. Intravenous fluids/blood transfusion
5. Initial sepsis evaluation (CBC, blood culture and treatment in an asymptomatic patient on the first day of evaluation)
6. Apnea/bradycardia not meeting criteria in NICU level of care
7. Neonatal abstinence syndrome when (NAS) score are: greater than or equal to 8 on three consecutive scores or greater than or equal to 12 on two consecutive scores. (Medical Director consult required prior to assignment)

CONVALESCENT – Revenue Code 172

1. Phototherapy – intensive (double phototherapy or greater)
2. IV heplock meds
3. Neonatal Abstinence Syndrome when (NAS) scores are < 8
4. No Apnea/Bradycardia (greater than 48 hours since last episode, and otherwise meeting detained Level of Care I criteria.)
5. Diagnostic work-up/surveillance, otherwise stable using >1 consultant and/or diagnostic test.
6. Temperature instability
7. Advancing to full volume feeds
8. Stable with sub-optimal PO
9. Apnea countdown
10. Post hemorrhagic hydrocephalus

11. Growing preemie
12. Growing preemie who is stable except O_2 with feeds

DETAINED/NORMAL – Revenue Code 171

1. Diagnostic work-up/surveillance otherwise stable using 1 consultant or diagnostic test
2. Routine well baby care
3. Phototherapy (single source phototherapy)

Neonatal level of care determinations are subject to interpretation by the Alere Care Manager and Medical Director. The hospital representative has the right to discuss a determination with the Alere Care Manager and/or Medical Director and is provided the right to appeal levels of care assigned.

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

- Provides free aids and services to people with disabilities to help them communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Health Net Customer Contact Center at
Individual & Family Plan (IFP) Members On Exchange/Covered California
1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call one of the phone numbers above or write to:

Health Net
Post Office Box 9103, Van Nuys, California 91409-9103

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769

- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

- Electronically: Send an email to SM_Section1557Coord@centene.com This notice is available at Health Net website: https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html

If your health problem is urgent, if you already filed a complaint with Health Net and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange: 1-800-839-2172（TTY: 711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY: 711）または Small Business 1-888-926-5133（TTY: 711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY: 711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníłł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

OUTPATIENT CALIFORNIA HEALTH NET COMMERCIAL AUTHORIZATION FORM

Complete and **Fax to: 844-694-9165**
Transplant **Fax to: 833-769-1142**
Behavioral Health
Requests **Fax: 855-663-2244**

HMO

POS

PPO

Request for additional units. Existing Authorization Units

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

Last Name, First *Date of Birth

MEMBER INFORMATION

*Member ID (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI *Requesting TIN Phone

Requesting Provider *Address* *Fax

City, State, ZIP

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider Servicing Provider Contact Name -

*Servicing NPI *Servicing TIN - Phone

Servicing Provider/Facility Name *Address* Fax

City, State, ZIP

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

***Start Date** OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

(Enter the Service type number in the boxes)

*OUTPATIENT SERVICE TYPE

412 Auditory
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyberbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
211 OB Ultrasound
410 Observation
997 Office Visit/Consult
210 Orthotics
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health

533 BH Applied Behavioral Analysis
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME

417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Rev.05062025
XD-PAF-1654

Outpatient Authorization Supplemental Form

This page is optional and meant to be used when an authorization request exceeds more than four (4) Procedure Codes. When applicable, please submit this form with the Outpatient Prior Authorization Form to the applicable fax number.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

* Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
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Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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Palliative and Hospice Care Contracted Provider List

Contracted Providers - Preferred List

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Anchor	1435 N. McDowell Blvd., Ste. 210, Petaluma, CA 94954	North Bay (Sonoma, Marin, Napa, Solano); East Bay (Alameda, Contra Costa); South Bay (San Mateo, San Francisco, Santa Clara, Monterey); San Joaquin, Sacramento, Yolo, El Dorado, Placer, Lake	X	X	415-598-0944 707-321-0046	415-598-0955	www.anchorhpc.com
Community Hospice, Inc., a Californian non-profit corporation	4368 Spyres Way Modesto, CA 95356	San Joaquin Stanislaus, Merced, Calaveras, Mariposa, Tuolumne, and portions of surrounding counties	X	X	209-578-6300	209-541-3280	www.hospiceheart.org
Hinds Hospice	1416 W. Twain Ave, Fresno, CA 93711	Fresno, Merced, Madera, Mariposa	X	X	559-226-5683	559-222-4782	www.hindslifecare.org

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Palliative and Hospice Care Contracted Provider List

Contracted Providers - Preferred List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Libertana Home Health of Sherman Oaks	5805 Sepulveda Blvd., Ste. 605 Van Nuys, CA 91411	Los Angeles	X	X	818-902-5000 800-750-1444	818-902-5008	www.libertana.com
Lightbridge Hospice, LLC & Palliative Care	6155 Cornerstone Ct. East, Ste. 220 San Diego, CA 92121	San Diego	X	X	858-458-2992	858-362-4027	www.lightbridgehospice.com
Noble Hospice Care, Inc.	6601 Owens Dr., Ste. 245 Pleasanton, CA 94588	Solano, Alameda, San Francisco, San Mateo, Santa Clara, Contra Costa	X	X	925-594-1122	925-520-2411	www.noblehhc.com
Providence Hospice LA County	5315 Torrance Blvd. Torrance, CA 90503	Los Angeles	X	X	800-329-8660	310-424-4228	www.compassus.com
ResolutionCare, PC (Vynca)	1875 S. Grant St., Ste. 760 San Mateo, CA 94403	Humboldt, Mendocino	X	N/A	707-442-5683 888-227-8884	707-442-2006 833-593-2739	www.vyncacare.com
Roze Room Healthcare	2700 E. Foothill Blvd., Ste. 200 Pasadena, CA 91107	Los Angeles, Ventura, San Bernardino	X	X	877-783-0072	818-462-5854 877-783-4783	www.rozeroom.org
Silverado Supportive Care	27710 Jefferson Ave., Ste. 200 Temecula, CA 92590	Los Angeles, San Bernadino, Riverside, San Diego, Orange	X	X	888-491-0049	866-299-8639	www.silveradohospice.com
Snowline Hospice	6520 Pleasant Valley Rd. Diamond Springs, CA 95619	Sacramento, El Dorado, West Slope, Placer, Yolo	X	X	530-621-7820	530-621-4503	www.snowlinehealth.org

Contracted Providers - Preferred List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
The Elizabeth Hospice	800 W. Valley Pkwy., Ste. 100 Escondido, CA 92025	San Diego, Southwest Riverside	X	X	833-349-2052	760-796-3781	www.elizabethhospice.org

Contracted Providers - Secondary List

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Assisted Home Hospice - Northern Hills	10550 Sepulveda Blvd., Ste. 101 Mission Hills, CA 91345	Mission Hills/ Los Angeles	X	X	818-830-5003	818-830-5019	www.assistedcares.com
Assisted Home Hospice - Ventura	4450 Westinghouse St., Ste. 103 Ventura, CA 93003	Ventura	X	X	805-677-7405	805-677-7441	www.assistedcares.com
Assisted Home Hospice - Los Angeles	3731 Wilshire Blvd., Ste. 518 Los Angeles, CA 90010	Los Angeles	X	X	213-355-3511	213-355-3516	www.assistedcares.com
Assisted Home Hospice - Santa Barbara	115 E Micheltorena St., Suite 100 Santa Barbara, CA 93101	Santa Barbara	X	X	805-569-2000	805-722-1459	www.assistedcares.com
Carechoices Hospitc eand Palliative Services, Inc.	20 Corporate Park, Ste. 300 Irvine, CA 92606	Orange	X	X	949-777-8600	949-777-8601	www.carechoices.net
Hoffman Hospice Of The Valley, Inc.	4325 Buena Vista Rd. Bakersfield, CA 93311	Kern, Victorville, Los Angeles	X	X	661-410-1010	661-410-1110	www.hoffmannhospice.org

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Palliative and Hospice Care Contracted Provider List

Contracted Providers - Secondary List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Hospice of East Bay	3470 Buskirk Ave. Pleasant Hill, CA 94523	Alameda, Contra Costa, Solano	X	X	925-887-5678	925-887-5679 (Hospice)	www.hospiceeastbay.org
Hospice of East Bay	2849 Miranda Ave. Alamo, CA 94507	Alameda, Contra Costa, Solano	X	X	925-945-8924 925-945-0863	925-852-0010 925-852-0044 (Palliative)	www.hospiceeastbay.org
Skirball - JHA Geriatric Services, Inc., a subsidiary of the Los Angeles Jewish Home	6345 Balboa Blvd., Ste 315 Encino, CA 91316	Los Angeles	X	X	877-774-3040	818-774-3089	www.skirballhospice.org

N/A = Not applicable

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Do not photocopy this form. The information contained is confidential and peer-review protected.

Check one:

☐ Medical/physical medicine PQIs (Complete all fields and forward immediately **via secure fax: 877-808-7024**)
☐ Behavioral health PQIs (Complete all fields and forward immediately **via secure email: pqi@healthnet.com**)

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

Important

The PQI Referral Form is a confidential document used by the Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to Health Net enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner.

Refer issues identified as *member appeals* or *member grievances* to the Member Appeals and Grievances Department for appropriate case handling and resolution.

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

Referral Content

1. All the fields on the PQI form are **required** fields.
2. Use the fillable PDF form to complete the PQI referral. Do not fax a handwritten PQI referral form. Handwritten PQI forms will be returned to originator for proper re-submission.
3. All sections of the PQI referral must be completed.
4. The form should be completed as follows:
    a) Referral source - Include referral date, first and last name of the associate completing the referral, contact information (telephone number, fax number) and the name of the associate who identified the PQI. If same as the referred by, enter *same as referred by* in this section.
    b) Member demographics – Include member first and last name, member ID, member's current primary care physician (PCP) and the associated participating physician group (PPG).
    c) PQI Event Dates / Filed Against Details – Include date of event, first and last name of practitioner that PQI is filed against (if same as PCP, re-enter PCP and PPG name here) and practitioner's office location. If hospital, please include name of hospital and location. Provide an admission date. Indicate the type of PQI using the check box items provided on the PQI referral. In the description of event field, describe event(s) chronologically, including dates, provider or practitioner names, specify any equipment or medication involved, quote relevant statements made by the provider or others and provide a complete explanation describing the potential deviation in the standard of care.
5. Complete and submit this report directly within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
6. Incomplete referral forms are returned to the associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

Referral Source

Referral date:_____

Referred by *(First, Last Name)*: _____

Identified by *(First, Last Name)*: _____

Phone number: _____

Fax number: _____

Member Demographics

Member name *(Last, First, MI)*: _____

ID#: _____

Current primary care physician (PCP): _____

Current participating physician group (PPG): _____

PQI Event Dates

Date(s) of PQI event:_____

Admission date:_____

Prior admission dates (if applicable): _____

_____

Filed Against Details:

Provider/Practitioner name: *(First, Last or name of facility)*: _____

Associated Provider/Practitioner PPG: _____

Provider/Practitioner location: _____

Provider/Practitioner NPI#:_____

HAC/HCAC, OPPC, SRAE, & and other PQI Indicators

Surgical events:

- ☐ **Surgery on wrong body part**
- ☐ **Surgery on wrong patient**
- ☐ **Wrong surgical procedures on a patient**
- ☐ **Foreign object retained after surgery**
- ☐ Anesthesia adverse event
- ☐ **Surgery with post-operative/intra-operative death in a normal healthy patient**
- ☐ Acute MI or CVA within 48 hours after elective surgery
- ☐ Cardiac or respiratory arrest in the operating room (OR)
- ☐ Unplanned return to OR, unplanned removal, injury or repair of an organ
- ☐ Other (explain) _____

Surgical site/post-operative infections:

- ☐ **Mediastinitis after coronary artery bypass graft (CABG)**
- ☐ **Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)**
- ☐ **Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip**
- ☐ Other (explain) _____

Bolded text indicates HAC/HCAC, OPPC or SRAE

Patient death/disability:

- ☐ Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- ☐ Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- ☐ Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended
- ☐ Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- ☐ Unexpected death (Please explain) _____

Patient issue:

- ☐ Member leaves against medical advice (AMA) when there is a potential for serious adverse event(s)
- ☐ Patient suicide attempt or serious injury to self while in treatment
- ☐ Other (explain)_____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Hospital-acquired (nosocomial) infections:

- ☐ **Catheter-associated urinary tract infection (UTI)**
- ☐ **Vascular catheter-associated Infection**
- ☐ Other (explain) _____

Deep vein thrombosis or pulmonary embolism following orthopedic procedures:

- ☐ **Total knee replacement**
- ☐ **Total hip replacement**
- ☐ Other (explain) _____

Falls (with trauma):

- ☐ **Fractures**
- ☐ **Dislocations**
- ☐ **Intracranial injuries**
- ☐ Other (explain) _____

Injury:

- ☐ **Crushing injuries**
- ☐ **Burns**
- ☐ **Electric shock**
- ☐ Other (explain) _____

Manifestations of poor glycemic control:

- ☐ **Diabetic ketoacidosis**
- ☐ **Nonketotic hyperosmolar coma**
- ☐ **Hypoglycemic coma**
- ☐ **Secondary diabetes with ketoacidosis**
- ☐ **Secondary diabetes with hyperosmolarity**

Obstetrics:

- ☐ Nonmedically indicated (elective) delivery less than 39 weeks gestational age
- ☐ Newborn Apgar < 4 at 1 minute or < 6 at 5 minutes

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Admission/readmission/discharge:

- ☐ Unexpected / unanticipated readmission within 30 days to acute level of care with same or similar diagnosis or as a complication of the previous admission
- ☐ Unplanned admission following diagnostic test or outpatient procedure
- ☐ Neurological deficit present at discharge not present on admit
- ☐ Delay in transfer/treatment or discharge – which results in a poor outcome to the member or additional costs to the plan
- ☐ Delayed diagnosis or missed diagnosis – resulting in adverse member outcome or extended hospital stay
- ☐ **Infant discharged to the wrong person**

Outpatient/ambulatory care:

- ☐ Breach of member confidentiality or ethics concern/violation
- ☐ Abnormal diagnostic study not followed up appropriately where the potential for adverse outcome exists
- ☐ Inattention to or lack of appropriate follow-up of consultant's major recommendations without appropriate rationale
- ☐ Practitioner's failure to follow-up on any member's significant complaint or physical finding within a reasonable period of time
- ☐ Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
- ☐ Hospitalization resulting from inappropriate drug therapy

Other:

- ☐ Pressure ulcer stages III & IV occurring after hospital admission
- ☐ Air embolism
- ☐ Blood transfusion incompatibility
- ☐ Any substandard care with the potential for harm to the member (please explain fully) _____
- ☐ Member refused to file a grievance
- ☐ Grievance withdrawal
- ☐ Other (select only when no other selection is applicable and explain fully) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS	BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Behavioral health:

- ☐ Inadequate assessment
- ☐ Inadequate treatment strategy or intervention
- ☐ Quality of patient relationship with provider appears very poor
- ☐ Inadequate discharge planning or follow-up
- ☐ Failure to utilize appropriate collateral contacts and/or coordinate care
- ☐ Lack of timely intervention that doesn't involve medication
- ☐ Patient's condition requires medication evaluation, but no referral was made
- ☐ Incident of drug/alcohol use in a facility
- ☐ Incident of possession of a weapon in a facility
- ☐ Situation where provider/facility acted in such a way as to create potential safety concerns
- ☐ Patient assaulting or causing serious injury to other or other criminal activity
- ☐ Use of restrictive interventions (seclusion, restraints, isolation) inconsistent with accepted standards and regulations
- ☐ Clinical risk inadequately assessed or managed
- ☐ Medication error, incident or concern
- ☐ Alleged abuse of child, adolescent or elder not reported to appropriate authorities

Description of event:
Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary – must be typed, not handwritten):

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Prescription Drug Prior Authorization or Step Therapy Exception Request Form (No. 61-211) Contact Information

Please use the **Prescription Drug Prior Authorization or Step Therapy Exception Request form (No. 61-211)** when submitting prior authorization requests for prescription drugs. The form is attached below and is available on the Health Net* provider library under "Forms and References" at:

- Medi-Cal: https://providerlibrary.healthnetcalifornia.com/medi-cal/forms.html/HMO
- HMO: https://providerlibrary.healthnetcalifornia.com/hmo/forms.html/
- PPO: https://providerlibrary.healthnetcalifornia.com/ppo/forms.html

Requests made with incorrect forms will be returned to the provider or facility for resubmission.

When submitting a form for Health Net members, please note the contact information differs based on the type of prior authorization request being made.

Prior authorization contact information: Commercial (HMO and PPO)

Prior authorization type	Contact	Fax	Phone
Pharmacy and self-injectable requests	**Pharmacy services**	866-399-0929	800-548-5524 Option 2
Physician-administered medications	**Pharmacy services**	844-235-5090	800-867-6564 Option 2

Prior authorization contact information: Medi-Cal

Prior authorization type	Contact	Fax	Phone
Self-administered medication requests	**Medi-Cal Rx**	800-869-4325	800-977-2273
Physician-administered medications	**Pharmacy services**	833-953-3436	800-867-6564 Option 2

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PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/medical group name: _____ **Plan/medical group phone number:** _____

Plan/medical group fax number: _____ **Non-urgent** ☐ **Exigent circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA).**

Member Information

First name:	Last name:	MI:	Phone number:	
Address:	City:		State:	ZIP Code:
Date of birth:	☐ Male ☐ Female	Circle the unit of measure Height (in/cm):____ Weight (lb/kg):____	Allergies:	
Member's authorized representative (if applicable):		Authorized representative phone number:		

Insurance Information

Primary insurance name:	Member ID number:
Secondary insurance name:	Member ID number:

Prescriber Information

First name:	Last name:	Specialty:	
Address:	City:	State:	ZIP Code:
Requestor (if different than prescriber):	Office contact person:		
National provider identifier (NPI) (individual):	Phone number:		
Drug enforcement administration (DEA) (if required):	Fax number (in HIPAA compliant area):		
Email address:			

Medication/Medical and Dispensing Information

Medication name:

☐ New therapy ☐ Renewal ☐ Step therapy exception request
If Renewal: Date Therapy Initiated: Duration of therapy (specific dates):

How did the member receive the medication?
☐ Paid under Insurance Name:_____ Prior auth number (if known):_____
☐ Other (explain):

Dose/strength:	Frequency:	Length of therapy/number refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration location:
☐ Member's home ☐ Long term care
☐ Physician's office ☐ Home care agency ☐ Other (explain):_____
☐ Ambulatory infusion center ☐ Outpatient hospital care

Revised 7/2025 Form 61-211

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Member name:	ID number:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request.

1. Has the member tried any other medications for this condition? ☐ **Yes (if yes, complete below)** ☐ **No**

Medication/therapy (Specify drug name and dosage)	**Duration of therapy** (Specify dates)	**Response/reason for failure/allergy**

2. List diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step-therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber signature or electronic ID verification:_____ **Date**:_____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/time request received by plan/insurer:_____ Date/time of decision_____

Fax number_____

☐ Approved ☐ Denied Comments/information requested: _____

BE INFORMED

If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment pursuant to Section 1704.7 of the California Health & Safety Code.

The information about methods of treatment was developed by the State Department of Health Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures.

INFÓRMESE

Si es usted un paciente que está recibiendo tratamiento contra cualquier forma de cáncer de próstata, o en la etapa prévia a una biopsia por cáncer prostático, su médico o cirujano está urgido dar a usted un sumario escrito de los métodos alternativos de tratamiento disponibles considerados eficaces. Esto es en cumplimiento con la Sección 1704.7 del Código de Salud y Seguridad del Estado de California.

La información sobre los métodos de tratamiento fueron desarrollados por los Servicios de Salud del Estado de California para informar a los pacientes sobre las ventajas y desventajas, riesgos y descripciones de los procedimientos.

通知

如果你是前列癌病患者或如要进行前列腺癌的切片測驗，按照加省衛生安全規則第 1704.7 部份，你的醫生必要向你提供一份有關各種有效治療的報告書。

各種治療的資料是由國家衛生服務局所提供，來使病人知道各種不同治療的好處、壞處、危險和治療的程序。

Provider Dispute Resolution Request

Commercial and Medi-Cal

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

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21-225a/FRM047551EC00 (3/21)

Commercial and Medi-Cal Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

21-225a/FRM047551EC00 (3/21)

Provider Dispute Resolution Request

Individual Family Plan (IFP)

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-641-7761.
- Mail the completed form to the following address.

  IFP Provider Disputes and Appeals Unit
  PO Box 9040
  Farmington, MO 63640-9040

INSTRUCTIONS

Please mark the member's line of business:

☐ HMO/POS
☐ PPO
☐ PureCare HSP
☐ PureCare One EPO
☐ CommunityCare HMO
☐ EnhancedCare PPO
☐ PPO Individual and Family

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab ☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute ☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

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20-690/FRM047550EC00 (9/20)

IFP Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-641-7761.
- Mail the completed form to the following address.

  IFP Provider Disputes and Appeals Unit
  PO Box 9040
  Farmington, MO 63640-9040

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

20-690/FRM047550EC00 (9/20)

Provider Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 844-561-8741.**

*Required Field

Member Information

***Member ID #:**

First Name:

Last Name:

***Birth Date MMDDYYYY:**

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

***First and Last Name:**

Phone Number: *TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

*Member ID #:

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

- ☐ Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)
- ☐ Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
- ☐ Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
- ☐ Member does not have any current physical, behavioral, or social drivers of health needs
- ☐ Other

Please explain

Previous Pregnancy History (Please check all that apply)

- ☐ History of preterm delivery
- ☐ History of C-Section
- ☐ History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)
- ☐ Member does not have any previous pregnancy conditions
- ☐ Other

Please explain

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Rev. 04182024
XD-PNOP-1932
25-437

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! =Report immediately by telephone (designated by a ♦ in regulations).
† =Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ =Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
=All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae,* invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

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* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

Health Net of California, Inc. and
Health Net Life Insurance Company

Confidential Communication Request

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) want you to know that you have a choice about your protected health information (PHI). You can have Health Net send any communication that has PHI directly to you instead of the main subscriber of your family's health policy.

PHI is health information about you. Examples of communications that include PHI are:

- Explanation of benefits notices.
- Information about your appointments.
- Claim denials, requests for additional information about claims, and notices of contested claims.
- The name and address of your provider, descriptions of services provided and other visit information.

Complete this form if you'd like us to send communications that contain PHI directly to you, instead of the Subscriber, at a different mailing or email address. Note: You may receive notifications regarding Explanation of Benefits, ID cards, information about your claim(s), and provider information via email. If you wish to view this information online, please log in to our secure portal at **www.healthnet.com**.

Please mail or FAX this completed form to Health Net. Allow 14 days for us to process your request.

MAIL: Health Net, Membership Accounting, CA-100-04-03, PO Box 9103, Van Nuys, CA 91409-9103
FAX: (818) 676-7411, Attention: Health Net Membership Department

We're here to help! Please call us if you have questions: **1-800-522-0088**

Tip! If you enroll in health coverage with a different company, you will have to let them know how you want your PHI handled.

Your information		
First name:	Last name:	Birth date:
Subscriber ID number:	Phone number: *Where we can call you if we have questions?*	
Yes! Please send communications with my PHI to this mailing address and/or email address:		
Mailing address:		
City:	State:	ZIP:
Email address:		
Note: You will receive notification of Explanation of Benefits, ID cards, information about your claim(s), and provider information via email. If you wish to view this information online, please log in to our secure portal at **www.healthnet.com**.		
I certify and acknowledge that the above information is true and correct.		
Signature:		Date:

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FRM004967ER00 (1/16)

Transitions of Care Management (TRC) Worksheet

Patient Name: _____ DOB: ____/____/____ Member ID: _____

Discharge Facility: _____ Admit Date: ____/____/____ Discharge Date: ____/____/____

PCP or Ongoing Care Provider Name: _____

Transitions of Care – Notification of Inpatient Admission (TRC-NIA)

Date of Admission Notification: _____/_____/_____

Method of Notification:

☐ Phone ☐ Email/Fax ☐ Shared EMR ☐ ADT Feed ☐ HN Provider Portal ☐ HIE Portal

☐ Provider performed a preadmission exam (not pre-op exam) or received notification of a planned admission prior to the admit date.

☐ Other: _____

TRC - Notification of Inpatient Admission: No Administrative Codes available-documentation review required.

Transitions of Care – Receipt of Discharge Information (TRC-RDI)

Date of Receipt of Discharge: _____/_____/_____ (includes the day of discharge through 2 days post discharge) TRC-RDI

Method of Notification:

☐ Phone ☐ Email/Fax ☐ Shared EMR ☐ ADT Feed ☐ HN Provider Portal ☐ HIE Portal ☐ Other: _____

Discharge Summary Included: ☐ Yes ☐ No

If discharge summary is not included, complete all information below:

The practitioner responsible for the member's care during the inpatient stay: _____

Procedures of treatment provided: _____

Diagnosis at discharge: _____

Current medication list: _____

Testing results, or documentation of pending tests or no tests pending: _____

Instructions for patient care post-discharge: _____

TRC - Receipt of Discharge Information: No Administrative Codes available - documentation review required.

Transitions of Care – Patient Engagement (TRC-PE)
Please use this as a guide to submit the appropriate codes for services completed.

CPT Copyright 2023 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. TRC - Patient Engagement After Discharge

Outpatient Visits If YES, date: _____/_____/_____

CPT Codes Submitted (99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347-99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483): ☐ Yes ☐ No

HCPCS Codes Submitted (G0402, G0438, G0439, G0463, T1015): ☐ Yes ☐ No

Telephone Visits

CPT Codes Submitted (98966-98968, 99441-99443): ☐ Yes ☐ No

Online Assessment (e-visit/virtual check-in)

CPT Codes Submitted (98969-98972, 98980, 98981, 99421-99423, 99444, 99457, 99458: ☐ Yes ☐ No

HCPCS Codes Submitted (G0071, G2010, G2012, G2061-G2063, G2250-G2252): ☐ Yes ☐ No

(continued)

Administrative codes for MRP
Please use this as a guide to submit the appropriate codes for services completed.

CPT Codes Submitted (99483, 99495, 99496): ☐ Yes ☐ No
CPT CAT II Code Submitted (1111F): ☐ Yes ☐ No

**If Other, Please Explain: _____

Do you need help?

☐ No
☐ Submitting CPT/CPTII codes
☐ Member with frequent readmissions
☐ Documentation review
☐ Contacting members
☐ MPR completed and in member's file.

If unable to submit CPT or CPTII code: **Complete the MRP form on the last page.**

Medication Reconciliation Post-Discharge provider assessment (MRP)

Please use this assessment form to help provide correct documentation needed to close the Medication Reconciliation Post-Discharge (MRP) Healthcare Effectiveness Data and Information Set (HEDIS) measure. Medication reconciliation needs to be completed on the date of discharge through 30 days after discharge (31 days total). After completion, place a copy of the completed form in the patient's record.

Member information

Patient Name: _____ DOB: ____/____/____ Member ID: _____

Medication Reconciliation Date: ____/____/____ Post-Discharge Hospital Follow-Up Visit: ☐ Yes ☐ No

Discharge information

Discharge Date: ____/____/____

Admission Diagnosis: _____

Diagnosis Discharge: _____

Facility: _____ Hospitalist: _____

List of medications current and discharge
Document all prescriptions, over-the-counter and herbal supplements below.

Date Reviewed: ____/____/____

☐ Patient was not prescribed any medications upon discharge.
☐ Patient's discharge and current medication list is attached.

Drug name	Dose at discharge	Frequency

Provider Name (Print): _____

Credentials: ☐ RN ☐ MD ☐ DO ☐ NP/APRN ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____ Date: ____/____/____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.
If medications were reconciled during office visit, or if this form is completed, please submit Code 1111F to the health plan to capture compliance.

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23-1222/FRM1323151ECO1w (12/23)

Health Net Transplant Performance Centers

UPDATED: 11/13/25

Center FACILITIES NOT LISTED ARE NON-PAR. FOR NON-PAR RE-DIRECT OR REQUEST LOA	Transplant	Type	Wellcare California (Medicare) [Legacy Wellcare - CareCentral]	Wellcare by Health Net (Medicare) [Legacy Health Net - Trucare]	Line of Business UC B&G	GROUP HMO, POS Tier 1	PPO/EPO	OOS PPO	MEDI-CAL	AMBETTER HMO / PPO
California Pacific Medical Center - San Francisco	Kidney	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Cellic	X - Cellic	X - Cellic	X - Cellic	CIGNA NETWORK EFF 11/1/23	X - Cellic	X - Cellic
	Kidney-Pancreas (DHCS Adult)	Adult		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Pancreas	Adult (Medicare Certified)		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Liver-Kidney	Adult		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Heart (DHCS Adult)	Adult (Medicare Certified)		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
Cedars-Sinai Medical Center - Los Angeles	Lung - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Does not participate in LOB. No LOA required.	Non-Par	Non-Par	Non-Par	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD; LOA req'd.	NON-PAR
	Heart (DHCS Adult)	Adult (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Kidney	Adult / Pediatric (Medicare Certified Adult/Ped)			X - HN	X - HN	X - HN			X - OPTUM
	Liver - (DHCS Adult)	Adult (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Blood / Marrow (DHCS Adult)	Adult			X - HN	X - HN	X - HN			NON-PAR
		Autologous								
		Allogeneic Related & Unrelated								
Children's Hospital and Research Ctr at Oakland "Publicly know as UCSF Benioff Children's Hospital Oakland"	Blood / Marrow (DHCS PED)	Autologous	n/a	n/a	X - Optum	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	X-Covered under MOT agreement effective 1/1/22	X - OPTUM
		Allogeneic Related			X - Optum	X - Optum	X - Optum			
Children's Hospital of Los Angeles	Heart (DHCS Ped)	Pediatric (Medicare Certified)	n/a	n/a	X - HN	X - HN	X - HN	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Req'd.	X - OPTUM
	Intestinal (DHCS Ped)	Pediatric (Medicare Certified)			Non-Par	Non-Par	Non-Par			NON-PAR
	Liver - (DHCS Ped)	Pediatric (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Kidney	Pediatric (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Blood / Marrow (DHCS PED)	Pediatric			X - HN	X - HN	X - HN			X - OPTUM
		Autologous								
		Allogeneic Related & Unrelated								
Children's Hospital of Orange County - Orange	Blood / Marrow (DHCS PED)	Pediatric	n/a	n/a	X - HN	X - HN	X - HN	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Req'd.	X - OPTUM
		Autologous				X - HN	X - HN			
		Allogeneic Related & Unrelated				X - HN	X - HN			
City of Hope - Duarte	Blood / Marrow (DHCS Adult/Ped)	Pediatric	PPG Delegation for Transplant Auth; LOA Req'd	X - Cellic	X - Cellic	X - Cellic	X - Cellic	CIGNA NETWORK EFF 11/1/23	X - Cellic	X - Cellic
		Adult		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
Loma Linda University Medical Center - Loma Linda	Blood / Marrow (DHCS PED)	Pediatric	PPG Delegation for Transplant Auth; LOA Req'd	Does not participate in LOB - no LOA req'd	Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Required.	Non-Par (SCA Required)
	Heart (DHCS Adult/Ped)	Pediatric (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Kidney	Adult (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Pediatric (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Kidney-Pancreas (DHCS Adult)	Adult			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Pediatric			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Liver - (DHCS Adult)	Adult (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Pediatric			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Adult (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Pancreas	Pediatric			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
Lucile Packard Children's Hospital	Heart (DHCS Ped)	Pediatric (Medicare Certified)	n/a	n/a	X - Cellic	X - Cellic	X - Cellic	CIGNA NETWORK EFF 11/1/23	X - Cellic	X - Cellic
	Intestinal (DHCS Ped)	Pediatric (Medicare Certified)			SCA REQD	SCA REQD	SCA REQD		X - Cellic	SCA REQD
	Heart-Lung	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Kidney	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Liver - (DHCS Ped)	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Lung - (DHCS Ped)	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Blood / Marrow (DHCS PED)	Pediatric			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
		Autologous								
		Allogeneic Related & Unrelated								
Rady Childrens Hospital	Heart - (DHCS Ped)	Pediatric (Medicare Certified)	n/a	n/a	X - Optum	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. No LOA req'd.	X - OPTUM
	Kidney	Pediatric (Medicare Certified)			X - Optum	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS PED)	Pediatric			X - Optum	X - Optum	X - Optum			X -OPTUM
		Autologous								
		Allogeneic Related & Unrelated								
Scripps Health - San Diego	Kidney	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Optum	X - Optum	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. No LOA required.	X - OPTUM
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Liver	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Pancreas	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS Adult)	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
		Autologous								
		Allogeneic Related & Unrelated								

Health Net Transplant Performance Centers

UPDATED: 11/13/25

Center FACILITIES NOT LISTED ARE NON-PAR. FOR NON-PAR RE-DIRECT OR REQUEST LOA	Transplant	Type	Wellcare California (Medicare) [Legacy Wellcare - CareCentral]	Wellcare by Health Net (Medicare) [Legacy Health Net - Trucare]	UC B&G	Line of Business GROUP HMO, POS Tier 1	PPO/EPO	OOS PPO	MEDI-CAL	AMBETTER HMO / PPO
Sharp Healthcare System	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - HN	X - HN	X - HN	X - HN	CIGNA NETWORK EFF 11/1/23	X - HN Agreement	X - OPTUM
	Kidney	Adult (Medicare Certified)		X - HN	X - HN	X - HN	X - HN		X - HN Agreement	X - OPTUM
Stanford University Hospital - Palo Alto	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Celtic	X - Celtic	X - Celtic	X - Celtic	CIGNA NETWORK EFF 11/1/23	X - Celtic	X - Celtic
	Heart-Lung	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney-Pancreas	Adult		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Lung - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Pancreas after Kidney TP	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Blood / Marrow (DHCS Adult)	Adult Autologous Allogeneic Related & Unrelated		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
Sutter Medical Center Sacramento	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Does not meet Celtic criteria	Does not meet Celtic criteria	Does not meet Celtic criteria	Does not meet Celtic criteria	CIGNA NETWORK EFF 11/1/23	X - Celtic	Does not meet Celtic Criteria
	Blood / Marrow (DHCS Adult)	Adult Allogeneic Adult Autologous		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
UC Davis - Sacramento	Kidney	Adult Cadaveric & Adult Living (Medicare Certified)	PPG Delegation for Transplant Auth.	X - Optum	X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	X - HN Agreement, not covered under MOT	X - OPTUM
	Liver (DHCS Adult)	Adult (Medicare Certified)		X- HN effective 2/21/24	Non-Par	Non-Par	Non-Par		Covered under MOT agreement effective 8/8/24	Non-Par
	Blood / Marrow (DHCS Adult)	Adult Autologous Allogeneic Related & Unrelated		X - Optum X - Optum X - Optum	X - HN X - HN X - Optum	X - Optum X - Optum X - Optum	X - Optum X - Optum X - Optum		Covered under the MOT Agreement effective 1/1/22	X - OPTUM
UC San Diego - San Diego	Kidney	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Optum	X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	X - HN Agreement	X - OPTUM
	Heart - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - HN	X - Optum	X - Optum		Covered under the MOT Agreement effective 1/1/22	X - OPTUM
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - HN	X - Optum	X - Optum			X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - HN	X - Optum	X - Optum			X - OPTUM
	Heart-Lung	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Liver	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Pancreas	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS Adult)	Adult Autologous Allogeneic Related & Unrelated		X - Optum	X - HN	X - Optum	X - Optum			X - OPTUM
UCSF - SAN FRANCISCO	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Non-Par	Canopy Members: X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Covered under the MOT Agreement effective 1/1/22	X - OPTUM
	*Heart-Lung	Pediatric		Non-Par	Canopy Members: X - HN	Non-Par	Non-Par			NON-PAR
		Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric		Non-Par	Canopy Members: X - HN	Non-Par	Non-Par			NON-PAR
	Kidney	Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum		X - HN	X - OPTUM
		Pediatric (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum		X - HN	X - OPTUM
	Kidney-Pancreas (DHCS Adult)	Adult		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum		Covered under the MOT Agreement effective 1/1/22	X - OPTUM
	Liver - (DHCS Adult/Ped)	Pediatric		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
		Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
	Kidney-Liver	Adult/Pediatric		Non-Par	X - Optum	X - Optum	X - Optum			X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
	*Pancreas Autologous Islet Cell	Adult		Non-par	Canopy Members: X - HN	Non-Par	Non-par			NON-PAR
	Blood / Marrow (DHCS Adult/Ped)	Adult Pediatric Autologous Allogeneic Related & Unrelated		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM

Health Net Transplant Performance Centers

UPDATED: 11/13/25

Center FACILITIES NOT LISTED ARE NON-PAR. FOR NON-PAR RE-DIRECT OR REQUEST LOA	Transplant	Type	Wellcare California (Medicare) [Legacy Wellcare - CareCentral]	Wellcare by Health Net (Medicare) [Legacy Health Net - Trucare]	Line of Business UC B&G	GROUP HMO, POS Tier 1	PPO/EPO	OOS PPO	MEDI-CAL	AMBETTER HMO / PPO
Ronald Reagan UCLA Medical Center	Heart - (DHCS Adult/Ped)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd**	Does not participate in LOB, no LOA required	X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Required.** LOA's will only be granted if the member is an existing Continuity of Care patient.	X - OPTUM
		Pediatric (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Kidney	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Heart-Lung	Adult (Medicare Certified)			X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Pancreas	Adult			X - HN	X - Optum	X - Optum			X - OPTUM
	Liver - (DHCS Adult/Ped)	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Small Bowel - (DHCS Adult)	Adult (Medicare Certified Adult & Ped)			X - HN	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS Adult/Ped)	Adult			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric								
		Autologous								
		Allogeneic Related & Unrelated								
	Liver-Kidney	Adult			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric			X - HN	X - Optum	X - Optum			X - OPTUM
Keck Hospital of USC	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Celtic	X - Celtic	X - Celtic	X - Celtic	CIGNA NETWORK EFF 11/1/23	LOA	X - Celtic
	Heart-Lung	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney-Liver	Adult		X - Celtic	X - Optum	X - Optum	X - Optum		X - Celtic	X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney-Pancreas	Adult		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Blood / Marrow (DHCS Adult)	Adult		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
UC Irvine - Irvine NON-PARTICIPATING	Kidney - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Does not participate in LOB; no LOA required	Non-Par	Non-Par	Non-Par	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Required.	X - Optum
	Pancreas - (DHCS Adult)	Adult (Medicare Certified)			Non-Par	Non-Par	Non-Par			X - Optum
	Kidney-Pancreas (DHCS Adult)	Adult			Non-Par	Non-Par	Non-Par			X - Optum
	Blood / Marrow - (DHCS Adult)	Adult			Non-Par	Non-Par	Non-Par			Non-par

Abbreviations

[1]DHCS = Department of Health Care Services
[2]LOB = Line of business
[3]HN = Health Net
[4]CTU = Centralized Transplant Unit
[5]MCD = Medicaid
[6]LOA = Letter of Agreement
[7]n/a = not applicable
[8]MOT Agreement = Major Organ Transplant Agreement
[9]SCA = Single Case Agreement

Color Legend

Blue = Separates the listed centers
Orange = Non-participating (non-par) providers
Yellow = Column K shows yellow for Optum to differentiate from orange for non-par.

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING HOME HEALTH SERVICES

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for home health services regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used.

SERVICES TO BE PROVIDED
1. Type of services (for example, wound care, teaching, infusion):
2. Frequency of services:
3. How many visits are being requested?
4. How many visits have already been performed?
5. a. Start date of service: b. Anticipated completion date of services:

WOUND CARE
6. Current size of wound: Length_____Width_____Depth _____ Type_____ Amount of drainage_____

7. Type of wound care being performed:
8. Date and type of surgery or description of etiology of wound (for example, diabetic ulcer):

HOME INFUSION
9. Type of medication:
10. Frequency of services:
11. Is medication also being requested or is this request just for nursing? If medication is also being requested, please attach documentation describing patient's clinical diagnosis and medical records supporting the diagnosis, including applicable lab data.

HOME IV THERAPY
12. Type of medication:
13. Frequency of dosing:
14. Describe family/patient's ability/inability to self administer:
15. Diagnosis:

HOME HEALTH TEACHING
16. Document teaching needs, date teaching has been performed, and patient/family response to teaching:

ADDITIONAL QUESTIONS
17. Other services, please describe:
18. When will patient be independent in care? What steps are being taken to discharge from service and when is discharge anticipated?

Please attach physician’s order and documentation confirming homebound status and any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**



Ramon Munoz
Health Net

Verifying Eligibility

Individual and Family Plans

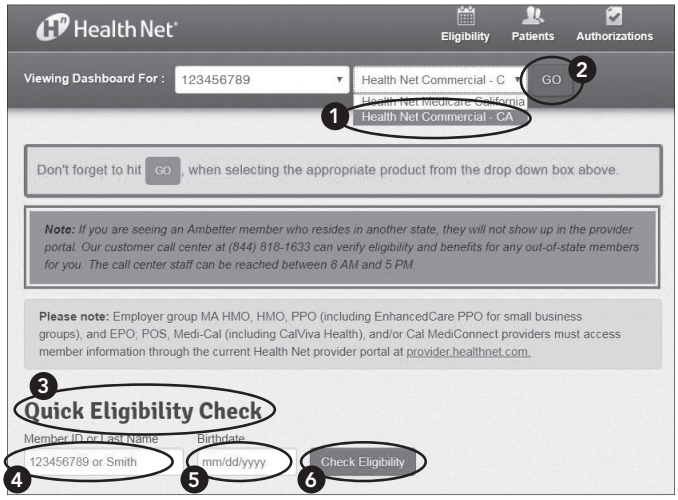
Verifying member eligibility

Log in to the new secure Health Net* provider portal at provider.healthnetcalifornia.com, and follow the steps below to verify Individual and Family Plans (IFP) member eligibility. There are two options for verifying eligibility. The second option allows the provider to change the date of service.

Verify eligibility at provider.healthnetcalifornia.com.

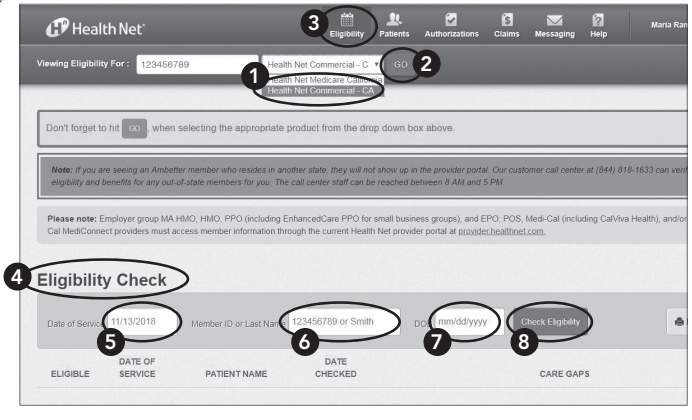
Option 1

1. Use the drop-down menu to choose *Health Net Commercial – CA*.
2. Select *Go.*
3. Use the Quick Eligibility Check.
4. Enter the member's identification (ID) number (or the member's last name).
5. Enter the member's date of birth (DOB).
6. Select *Check Eligibility* to view the member's information.



Option 2

1. Use the drop-down menu to choose *Health Net Commercial – CA*.
2. Select *Go.*
3. Select *Eligibility* at the top.
4. Use the Eligibility Check.
5. Change the date of service (DOS) if you need to verify a DOS for a prior date.
6. Enter the member's ID number or the member's last name.
7. Enter the member's DOB.
8. Select *Check Eligibility* to view the member's information.



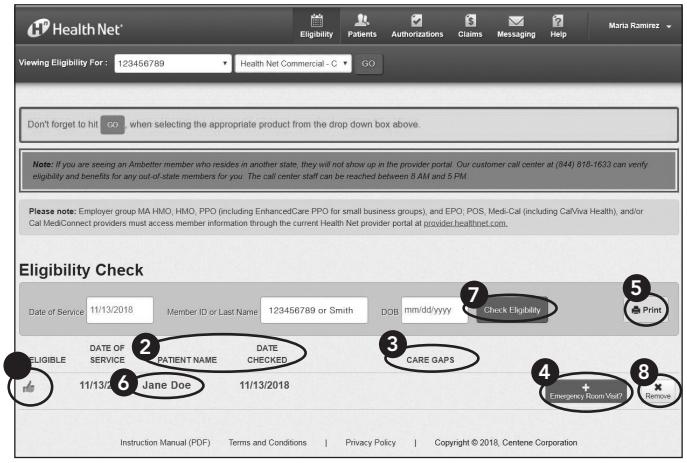
(continued)

Tips

- Include the "R" ID number; use only the letter and numbers listed (R12345678). Do not use MM1 or FS1.
- Include the full "U" ID number as displayed with the first letter and all numbers listed (such as U1234567801 or U1234567802 as listed on the card).
- If searching by last name, include the suffix, such as Jr., as listed on the member's ID card.
- Remember to also include the DOB since this is a required field.
- If the complete member ID number and DOB were entered and this does not provide eligibility status for the specific member you are verifying, try using the last name and DOB instead.
- If the IFP member status is not found on the Health Net provider portal at provider.healthnetcalifornia.com, confirm that the member has an IFP. If the member has an employer group commercial plan, then verify member eligibility through the original Health Net provider portal at provider.healthnet.com.

If the IFP member status is not found on the Health Net provider portal at provider.healthnetcalifornia.com, confirm that the member has an IFP.

Viewing Eligibility Check



1. The green thumbs-up indicates the member is eligible as of today's date or the date of service (DOS) entered for the member. (Only enter the DOS if it is not today's date.) If a thumbs-down appears, it means that the member is not eligible for that date of service, or you may be using the incorrect provider portal based on the member's plan type.
2. The patient name and date checked appear.
3. Care gaps are also included, if available.
4. An emergency room visit may be added to alert case managers of the member's recent activity, if applicable.
5. There is an option to also print the eligibility information for your records.
6. Select the hyperlink, which is the member's name, for additional patient information.
7. If you need to verify eligibility for another member, enter the member's ID number (or the member's last name) and DOB, and select *Check Eligibility.*
8. **Optional:** Participating physician groups (PPGs) may complete eligibility checks for members currently included in their group. If the member is not eligible, use the *Remove* button to delete that member before printing the list of eligible members.

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