PROVIDER*Update*



CONTRACTUAL

MAY 6, 2019

UPDATE 19-260

2 PAGES

Community-Based Adult Services (CBAS)

New dedicated fax line and CBAS Treatment Request form

Health Net* is notifying providers that, starting May 1, 2019, all face-to-face assessments, prior authorization requests and notifications for Community-Based Adult Services (CBAS) must be:

- · Submitted using the CBAS Treatment Request form, and
- Faxed to the dedicated CBAS line at 1-833-581-5908.

The CBAS Treatment Request form is available on the Health Net provider website at provider.healthnet.com under *Provider Library > Forms*. Include a fax cover sheet with faxes that have protected health information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

PRIOR AUTHORIZATION AND NOTIFICATIONS

Prior authorization is required for services exceeding five visits per week for the CBAS program as of January 1, 2019. CBAS service requests for one to five visits per week require notification only. These changes were communicated in provider update 18-798, *Prior Authorization Requirement Changes*, sent on October 24, 2018.

CBAS services	Requirement		
1–5 VISITS PER WEEK	Notification required		
GREATER THAN 5 VISITS PER WEEK	Prior authorization required		

ADDITIONAL INFORMATION

The Medi-Cal fee-for-services (FFS) prior authorization requirements have been updated online to reflect the information in this update. You can access the requirements on provider.healthnet.com as follows:

- Pre-log in Go to Working with Health Net > Policies for Non-Contracting Providers > Additional Resources > Services Requiring Prior Authorization.
- Post-log in Go to Working with Health Net > Contractual > Services Requiring Prior Authorization.

Relevant sections of Health Net's provider operations manuals have been revised to reflect the information contained in this update as applicable. Provider operations manuals are available electronically in the Provider Library, located on Health Net's provider website at provider.healthnet.com.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at provider_services@healthnet.com within 60 days, by telephone or through the Health Net provider website as listed in the right-hand column.

THIS UPDATE APPLIES TO CAL MEDICONNECT PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

provider_services@healthnet.com Los Angeles County – 1-855-464-3571 San Diego County – 1-855-464-3572 www.healthnet.com

PROVIDER COMMUNICATIONS provider.communications@healthnet.com

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Fax to:1-833-581-5908



CBAS TREATMENT REQUEST FORM

If you have questions about how to complete this form, please call Health Net at 1-866-801-6294, select option 1 to speak with a Referral Specialist.

X Expedited Request - Please	chack if this is for	Requesting Provider/CBAS Representative Signature Name (print) Date (MMDDYYYY) a new participant who is hospitalized or							
anticipated to be admitted * INDICATES REQUIRED FIELD			viio is nospitatize	u oi			_		
MEMBER INFORMATION	Member Te	Member Telephone Number *		Date of Birth *					
Member ID/Medi-Cal ID *		Last Name, First			(MMDDYYYY)				
PROVIDER/CBAS FACILITY			Dues did ou/OD	A					
Requesting Provider/CBAS Facility NPI	Requesting Prov	Requesting Provider/CBAS Facility TIN Provider/C		AS Facility Contact Name					
Requesting Provider/CBAS Facility Addre	988	City				ZIP Code			
Describe Describe (ODAO Facility Name		T-1							
Requesting Provider/CBAS Facility Name	e 	Telephone		Fax					
AUTHORIZATION REQUES	T/NOTIFICATIO	N (85109)				i			
Start Date	End Date	•	Quantity per Month		Diagnosis Code *				
(MMDDYYYY)	(MMDDYYYY)	MM/DDV/V/V		ίic	(ICD-10)				
Start Date End Date			Quantity per Month		Diagnosis Code *				
(MMDDYYYY)	(MMDDV/VV)			(10	D.10)				
Start Date	(MMDDYYYY) End Date		Quantity per Month		(ICD-10) Diagnosis Code *				
(MMDDYYYY) Start Date	(MMDDYYYY) End Date		Quantity per Month		D-10) agnosis Code *				
(MMDDYYYY) Start Date	(MMDDYYYY) End Date		Quantity per Month	(IC	D-10) agnosis Code *				
(MMDDYYYY)	(MMDDYYYY)		Qualities per month		D-10)				
SERVICES *	3-Day I	ndividual Plan of	Care (IPC)	Modific	ation² (Increase	o/Door	220)		
Face-to-Face Assessment ((T1023) Assessi	ment for New CBA	AS (H2000)		,	s/ Decre	;ase)		
Initial		Initial		Reinstate Services					
Modification	Medical Day Care Services (S510		ces (S5102)	Transfe	r				
² Please attach copy of History and Pl	hysical (H&P)	Initial		² Please attach IPC, participant attendance records					
with Face to Face Assessment request.		Continuation/Renewal ²		and transfer reason (if applicable) for continued authorization requests.					

FOR PRIOR AUTHORIZATION REQUEST ONLY: ALL REQUIRED FIELDS MUST BE FILLED IN. INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: Please check member eligibility prior to rendering services. A prior authorization is not a guarantee of payment. Payment may be denied in accordance with Plan's polocies and procedures applicable law.

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