Behavioral Health Services

PROVIDER OPERATIONS MANUAL

Health plans we support

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SECTION 1: OVERVIEW OF SERVICES

Behavioral health services vary by plan design. To determine a member's eligibility for services, please call the phone number on the member's identification (ID) card to consult with a Member Service representative. Our Member Service representatives and clinicians are available to providers and members 24 hours a day, seven days a week for crisis calls.

We communicate with members in 170 languages through its own staff and language line. Language services are offered at no additional cost. (***See Section 11.9)***

SECTION 2: IMPORTANT CONTACTS

2.1 Phone Directory and Contacts

Authorizations-Benefits-Eligibility-Interpreter Services

844-966-0298

8 a.m.-5 p.m. Pacific Time (PT)

Hospital or Facility Admissions

844-966-0298
Available 24/7 for hospital or facility admissions and for crisis support

Contracting

Email: DNBHC@healthnet.com

Claims Status

Individual & Family Plan – IFP (Ambetter HMO and PPO) or Medicare – provider.healthnetcalifornia.com

Commercial (Employer Group HMO/POS and PPO) or Medi-Cal – 800-444-4281
Behavioral Health Provider Services
Phone: 844-966-0298

Appeals

Urgent Appeals (Representing member) – Call:
844-966-0298Post-Service Provider Appeals – Written process, submit to address shown below and see section 12.4 of this manual.

Credentialing

Health Net Credentialing Department
Email (for facilities): HN_FacilitiesCredentialing@healthnet.com
Email (for practitioners): HNCredentialing_Practitioner_CA@Centene.com

Demographic Updates

Health Net Provider Data Management Team
Email: ProviderData@healthnet.com
Online: Demographic Update Forms

Include "Behavioral Health and participating physician Group (PPG) Name (if applicable)" to email subject line.

Technical provider portal support

Health Net Technical Support Team
Phone: 866-458-1047
Email: provider_services@healthnet.com

Important Mailing Addresses

Claims Submission

Submit paper claims with dates of service on and after January 1, 2024, to:

Medicare:

Health Net Medicare Claims
P.O. Box 9030
Farmington, MO 63640-9030

IFP:

Health Net Commercial Claims – IFP
P.O. Box 9040
Farmington, MO 63640-9040

Commercial:

Health Net Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

Medi-Cal:

For claims with dates of service on and after September 1, 2024, submit paper claims to:

Health Net Medi-Cal Claims
P.O. Box 9020
Farmington, MO 63640-9020

For claims with dates of service prior to September 1, 2024, submit paper claims to:

MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

Credentialing Documentation Submission

Health Net Credentialing Department
21281 Burbank Blvd - 2nd Floor
Woodland Hills, CA 91367

Practitioner Inquiries: HNCredentialing_Practitioner_CA@Centene.com

Facility Inquiries: HN_FacilitiesCredentialing@healthnet.com

Provider Dispute Resolutions

For disputes on claims with dates of service on and after January 1, 2024, send to the following address:

Medicare
P.O. Box 9030
Farmington, MO 63640-9030

Commercial
P.O. Box 989882
West Sacramento, CA 95798-9882

IFP
P.O. Box 9040
Farmington, MO 63640-9040

Medi-Cal
P.O. Box 989882
West Sacramento, CA 95798-9882

For disputes on claims with dates of service prior to January 1, 2024, send to the following address:

MHN Provider Appeals/Disputes
P.O. Box 989882
West Sacramento, CA 95798-9882

SECTION 3: PRACTITIONER RESPONSIBILITIES

3.1 Non-Discrimination

In Accordance with Section 1557 of the Affordable Care Act (ACA)

Participating behavioral health providers must provide or arrange for the provision of covered services to members seeking behavioral health services. The quality of covered services must be no less than the quality of services provided to other patients. Providers must not discriminate against members on the grounds that the member files a complaint against the provider, or because of the member's race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, income level, physical handicap, medical or mental health condition or on the basis of health maintenance organization membership.

Participating providers must notify Health Net immediately of a discrimination grievance submitted by a member and continue to follow Health Net's existing issue write-up procedures for detection and remediation of non-compliance.

Participating providers must comply with Health Net, regulatory or private litigation research, investigation and remediation requirements.

Participating providers must implement, enhance and reinforce prohibitions on discrimination on the basis of race, color, national origin, sex, age or disability. At a minimum, they must implement health program or activity changes to avoid discrimination where necessary.

Participating providers can consider implementing:

- An ability to capture gender identity;
- Mandatory provider and staff civil rights; or
- Cultural sensitivity training.

Accessibility for Persons with Disabilities

If necessary, participating providers must assess and enhance existing policies and procedures to ensure effective communication with members, including those with disabilities. Participating providers must ensure their 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 Americans with Disabilities Act (ADA).

3.2 Compliance with Requests for Provider Demographic Updates

Participating providers (including individual practitioners, groups and facilities) must cooperate with Health Net's efforts to keep current and up-to-date provider directories. Providers must supply information within the timelines requested by Health Net.

Health Net is required to contact directly contracting practitioners biannually, including behavioral health practitioners; and annually contact groups and facilities to validate the accuracy of the information for each provider listed in Health Net's provider directories. The notification includes:

- The information Health Net has in its directories for the provider, including a list of networks and products in which the provider participates.
- A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.
- Instructions on how the provider can update information including the option to use an online interface to submit verification or changes electronically which generates an acknowledgment from Health Net.
- A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the directories is current and accurate or to provide an update to the information required to be in the directories, including whether the provider is accepting new patients for each applicable Health Net network or product. Note: this requirement does not apply to general acute care hospitals. If Health Net does not receive an affirmative response and confirmation from the provider that the information is current and accurate, or as an alternative, receive updated information from the provider within 30 business days, the following will occur:
    - Health Net takes no more than an additional 15 business days to verify whether the provider's information is correct or requires updates. Health Net documents the receipt and outcome of each attempt to verify the information.
    - If Health Net is unable to verify whether the provider's information is correct or requires updates, Health Net notifies the provider 10 business days prior to removal that the provider will be removed from provider directories. The provider is removed from the provider directories at the next required update of the provider directories after the 10 business-day notice period. A provider is not removed from the provider directories if they respond before the end of the 10 business-day notice period. This requirement does not apply to general acute care hospitals.

Health Net will sometimes work with an outside vendor (i.e., Symphony Provider Directory) to reach out to providers to validate practitioner participation and demographic data. Providers are required to respond to requests from Health Net, and/or may update changes as needed directly with Symphony.

3.3 Notification of Practice and Demographic Information Changes

All providers must provide Health Net with their credentialing information, as well as their specialty, gender, work address, work fax number, work phone number and work email address for each of their health care delivery sites. Health Net is required to contact directly contracting practitioners biannually, including behavioral health practitioners; and annually contact groups and facilities to validate the accuracy of the information for each provider listed in Health Net's provider directories. The notification includes:

- The information Health Net has in its directories for the provider, including a list of networks and products in which the provider participates.
- A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.

- Instructions on how the provider can update information including the option to use an online interface to submit verification or changes electronically which generates an acknowledgment from Health Net.
- A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the directories is current and accurate or to provide an update to the information required to be in the directories, including whether the provider is accepting new patients for each applicable Health Net network or product. Note: this requirement does not apply to general acute care hospitals. If Health Net does not receive an affirmative response and confirmation from the provider that the information is current and accurate, or as an alternative, receive updated information from the provider within 30 business days, the following will occur:
    - Health Net takes no more than an additional 15 business days to verify whether the provider's information is correct or requires updates. Health Net documents the receipt and outcome of each attempt to verify the information.
    - If Health Net is unable to verify whether the provider's information is correct or requires updates, Health Net notifies the provider 10 business days prior to removal that the provider will be removed from provider directories. The provider is removed from the provider directories at the next required update of the provider directories after the 10 business-day notice period. A provider is not removed from the provider directories if they respond before the end of the 10 business-day notice period. This requirement does not apply to general acute care hospitals.

Health Net will sometimes work with an outside vendor (i.e., Symphony Provider Directory) to reach out to providers to validate practitioner participation and demographic data. Providers are required to respond to requests from Health Net, and/or may update changes as needed directly with Symphony.

Providers' demographic data information should include the following:

- Name.
- Alternate name.
- Address.
- Telephone number.
- Fax number.
- License number.
- National Provider Identifier.
- Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) registration number.
- 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.

3.4 Referrals

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) and/or California Department of Insurance (CDI), to report any inaccuracies with Health Net's directory.

3.5 Compliance with Credentialing Policies

Health Net's *Participating Provider Agreement* requires that practitioners comply with Health Net's credentialing policies. Under this agreement, practitioners must maintain a clear, unrestricted license to practice and notify Health Net within five (5) days of any of the following:

- Licensing actions
- Malpractice claims or arbitration.
- Felony indictments
- Disciplinary actions before a state agency
- Cancellation or material modification of professional liability insurance
- Actions taken to modify participation in Medicare or Medi-Cal
- Enrollee complaints against practitioner
- Any situation that would impact the practitioner's ability to carry out the provisions of the contract.

3.6 Credentialing: Administrative Guidelines

Credentialing and Re-credentialing

Practitioners in the Health Net network are selected and credentialed based on established criteria reflecting professional standards for education, training, and licensure. Eligible practitioners include psychiatrists, psychologists, clinical social workers, clinical nurse specialists and other Masters-level and independently licensed counselors. Credentials are verified upon initial

application to the network and through the recredentialing process thereafter, as required by regulatory and accrediting agencies. Information supplied to comply with credentialing requirements cannot be more than 180 days old at the time of the Credentialing Committee review.

Initial Credentialing

Physician-Level practitioners must meet the following selection criteria:

1. Graduation from an accredited medical school.
2. Current, unrestricted* medical license in the state in which practice is to occur.
3. Professional liability insurance coverage in the amount of $1 million per occurrence/$3 million aggregate or community standard as approved by Health Net.
4. Psychiatrists must have Board certification in psychiatry or completion of an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency in psychiatry.
5. Current controlled substances registration (DEA certificate).
6. Addictionologists must have current certification from the American Society of Addiction Medicine.
7. Current resume or curriculum vitae that details five years of relevant work history and clinical training (work absences must be explained by the applicant).
8. Foreign medical school graduates must submit an Educational Commission for Foreign Medical Graduates (ECFMG) certification to demonstrate proficiency in the English language.

Psychologist and Masters level practitioners must meet the following selection criteria:

1. Must hold a degree from a professional school. Graduation from an accredited graduate degree program with a clinically related curriculum.
2. Independently licensed in the state where practice is to occur, at the highest level in the state where practice is to occur.
3. Current, unrestricted* license in the state where practice is to occur.
4. Professional liability insurance in the amount of $1 million per occurrence/$1 million aggregate or community standard as approved by Health Net.
5. Current resume or curriculum vitae that details five years of relevant work history and clinical training (work absences must be explained by the applicant).
6. Registered nurses, nurse practitioners and clinical nurse specialists must have a state license that has language, or a designation related to a behavioral health specialty. If the state license does not have such language, or such language is not available, then a current American Nurses Credentialing Center (ANCC) certification in any of the following certification areas will meet these criteria:
    a. Clinical Specialist in Adult Psychiatric and Mental Health Nursing.
    b. Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing.
    c. Adult Psychiatric and Mental Health Nurse Practitioner.
    d. Family Psychiatric and Mental Health Nurse Practitioner.

***Unrestricted** is defined as having no current disciplinary investigations, conditions, or restrictions of any kind, including probation for any reason, imposed by the state licensing or certifying agency. Practitioners cannot be practicing under supervision.*

Registered Nurses, Nurse Practitioners and Clinical Nurse Specialists: Must be able to provide psychotherapy and attest to having a minimum of:

1. Master's degree in nursing or behavioral health-related area.
2. 36 semester hours of graduate level coursework in behavioral health counseling related subjects.
3. 1500 hours of supervised behavioral health experience in an outpatient psychotherapy setting.

Additional Practitioners Eligible for Admission into the Network Applied Behavioral Analysts (ABA)

ABA providers must meet the following selection criteria:

1. 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.
2. 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, Health Net requires an ABA license. All BCaBAs must deliver services under a group practice.
3. Must hold professional liability insurance in the amount of $1 million per occurrence/$1 million aggregate. A practitioner may have limits below these standards if the limits are consistent with the practitioner's community standard.
4. Must provide current resume or curriculum vitae detailing five years of relevant work history and clinical training (work absences of six months or more must be explained by the applicant). All practitioners must have documented relevant work history since initial licensure, or for five years, whichever is less.

In addition to the above, **all applicants** must report whether any of the following has occurred:

1. Felony conviction or misdemeanor conviction.
2. Pending felony allegation or misdemeanor allegation.
3. Sanctions by a federal or state payment program (e.g., Medicare, Medi-Cal).
4. Adverse professional review actions reported by any professional review board.
5. Denial, loss, suspension or limitation of medical license or narcotics license.
6. Malpractice claim, investigation or lawsuit filed.
7. Cancellation or material modifications of professional liability insurance.
8. Physical or mental condition or substance abuse problem which would impair ability to practice.

The following credentials are verified through primary sources:

1. Graduation from medical or other professional school appropriate to the state licensing requirement.
2. Current, valid license to practice independently.
3. Valid, unrestricted DEA or CDS certification, as applicable.
4. Board certification, as applicable.
5. Malpractice claims payment history from the National Practitioner Data Bank
   6. Department of Health and Human Services (DHHS) Medicare/Medi-Cal Sanctions.

Re-credentialing

Health Net re-credentials practitioners in its network every 36 months. Health Net conducts primary or secondary source verification on all credentials in the re-credentialing process.

Documents must not be more than 180 days old at the time of review.

All applicants for re-credentialing must report whether any of the following has occurred:

1. A felony conviction or misdemean or conviction.
2. A pending felony allegation or misdemean or allegation.
3. Sanctions by a federal or state payment program (e.g., Medicare, Medi-Cal, CMS).
4. Adverse professional review actions reported by any professional review board.
5. Denial, loss, suspension or limitation of professional license or narcotics license
6. Malpractice claim, investigation or lawsuit filed.
7. Cancellation or material modifications of professional liability insurance.
8. Physical or mental condition or substance abuse problem which would impair ability to practice.

Re-credentialing also includes a review of any prior quality issues and member complaint history.

Ongoing Monitoring of Sanctions

Health Net performs ongoing monitoring of Medicare/Medi-Cal sanctions and exclusions, board sanctions or licensure actions, and member complaint history. When participating practitioners are identified as being subject to these actions, they are presented to Health Net's Credentialing Committee for review and appropriate action.

Practitioner Rights Related to Credentialing and Re-Credentialing

Practitioners have a right to review information submitted in support of their credentialing and recredentialing applications (not including confidential evaluations or other confidential peer review documentation). In addition, if information obtained during the credentialing or recredentialing process varies substantially from information provided by the practitioner, Health Net will notify the practitioner in writing of any discrepancy. Practitioners have a right to correct erroneous information.

All information gathered in the credentialing and re-credentialing process is treated confidentially, except as otherwise provided by law. Credentialing and re-credentialing information is available to Health Net credentialing staff, peer and quality reviewers and credentialing committee members only on a need-to-know basis.

Practitioners are sent a written notification within 10 business days of the initial credentialing decision. Thereafter, practitioners are considered re-credentialed, unless otherwise notified by Health Net.

Delegated Credentialing

Health Net will delegate credentialing to practitioner organizations that can demonstrate their credentialing program meets all the requirements of Health Net, National Committee for Quality Assurance (NCQA).

Provider groups requesting delegation must send Health Net the following:

- Practitioner application
- Credentialing policies and procedures
- Practitioner rosters and data on each individual clinician either electronically or paper based.

Health Net will review the application and policies and procedures for compliance with Health Net and NCQA standards. If there are any identified areas of program non-compliance, the group will be informed and given an opportunity to submit a corrective action plan for approval.

The following requirements must be met:

1. The group must have an established credentials committee that reviews the credentials of potential clinicians in conjunction with quality management and utilization review committees. The meeting minutes of all committees involved in practitioner credentialing must be available for review during a site audit.
2. Health Net's Quality Management staff must be permitted reasonable access to the credential files, for the purpose of auditing credentialing activities, which must occur at least annually.
3. The group must have the administrative, technical expertise and financial capacity to carry out the delegated credentialing review functions.
4. The group is required to take appropriate action, outlined in its policies and procedures, any time a problem with an applicant's or a network clinician's credentials is identified. The practitioner must notify Health Net of any concerns regarding the clinician's credentials. In addition, the practitioner must forward to Health Net a narrative regarding the conclusions, recommendations, actions and follow-up of all credentialing cases in which disciplinary action, including denial, suspension, restriction, or

termination of network participation has been taken.

If there is an accusation, suspension, restriction, sanction or termination of any license or privilege against a clinician who has been credentialed by a delegated group, Health Net will notify the group requesting complete credentialing information on the clinician.

The group will respond to all requests for credentialing information within the specified time in the written inquiry. If the practitioner fails to respond within the specified time frame, Health Net retains the right to suspend or terminate the clinician in question at its sole discretion.

Health Net shall retain the ultimate responsibility for the approval, termination and/or suspension of clinicians to ensure all clinicians contracting with the plan meets the credentialing requirements specified in Health Net's Credentialing Policies and Procedures.

Delegated groups may perform obligations related to primary source verification and other credentialing documentation through an agent, Credentialing Verification Organization (CVO), or subcontractor.

If there is substantial non-compliance with Health Net standards, Health Net will conduct an audit of the delegated group's credentialing files to ensure adherence to the practitioner's process using Health Net's Credentialing Delegation Individual File audit tool and NCQA's file selection rule of 8/30, at a minimum. Health Net will review no fewer than 20 files— 10 initial files and 10 re-credentialing files. Delegated groups must pass the audit with a 90% or greater score.

If the files meet Health Net standards, the group will enter into a Credentialing Delegation Agreement with Health Net.

A group can be offered a provisional delegation agreement with an approved corrective action plan, if the group agrees that the corrective action can be completed within six months. All corrective action plans and delegation agreements must be approved by the Health Net Credentialing Committee along with the practitioner's roster identifying those individual clinicians who have successfully completed the practitioner's credentialing program.

Provisionally delegated provider organizations are re-audited within six months by Health Net to review the status of the corrective action plan and assure compliance.

The group's clinicians become active in the Health Net network **only** after receiving approval from the Health Net Credentialing Committee. Health Net retains the right to accept, reduce participation, suspend and/or terminate any clinicians who are members of delegated groups.

Practitioner Office Standards

1. 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 pets.
   - Office must have a separate waiting area with adequate seating.
   - Practitioners must see patients within 15 minutes of the scheduled appointment time.

- Clean restrooms must be available.
- Office environment must be physically safe.
- Practitioner 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.

2. Additional standards for practitioner home office:
   - 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.

Clinical Specialty Information

Clinical specialty information is collected and used in Health Net's referral process. Practitioners may update their clinical specialties online through their provider portal profile at healthnet.com.

Resignations and Network Terminations

Resignations

If a practitioner wishes to resign from Health Net's practitioner network, he or she must submit a written notice.

Please note that if you must resign from the Health Net network, you must notify Health Net within (90) days. It is your responsibility to work with Health Net to provide continuity of care for any member you are seeing; and you must be available to work with the member during that transition period. Facilitating an appropriate transition to another practitioner or service is good professional practice. We appreciate your cooperation.

Termination of Network Participation

Health Net can terminate a practitioner's network participation for a variety of reasons, including those specified in the practitioner contract. Network participation will **not** be terminated on the grounds that the practitioner:

- Advocated on behalf of a member.
- Filed a complaint against Health Net.
- Appealed a decision of Health Net.
- Requested a review or challenged a termination decision.

Please refer to the Termination provisions contained in your *Participating Provider Agreement* for specific details.

Types of Terminations

Termination with Clinical Cause

If Health Net considers terminating a practitioner from the network for clinical cause, Health Net will offer that practitioner the opportunity for a reconsideration or a hearing, as required by state

regulation. Health Net will notify the practitioner of the issues concerned and, where applicable, the reconsideration or hearing process. Practitioner termination will apply to all lines of business.

Termination without Clinical Cause

Health Net may terminate practitioners without clinical cause in accordance with the practitioner contract, based on the recommendation of the Credentialing Committee. Practitioners terminated from the network without clinical cause are offered appeal rights per Health Net's Credentialing Policies and applicable state and federal regulations.

Notification to Members of Contract Termination

The Plan must notify members at least 45 days prior to the termination date for contract terminations that involve a behavioral health provider. Also, the Plan must:

- Identify all members who are currently a patient of that behavioral health provider or who were a patient of that behavioral health provider within the past three years;
- Provide written notice to the identified members; and
- Make at least one attempt at telephonic notice to the identified members.

PPG/IPA notification of members for behavioral health specialist terminations: For Medicare HMO plans, capitated and shared-risk participating physician groups (PPGs) and independent practice associations (IPAs) must notify members in writing at least 30 days in advance of a specialist or ancillary provider termination effective date, and the template sent to members must be approved by CMS. The Plan's CMS-approved Medicare termination notification template (PDF) must be completed by the PPG/IPA and mailed to the member.

Templates for Only Medicare and DSNP Member Notification

To notify Medicare and DSNP members when a specialist terminates, PPGs must use the applicable template in the table below approved by the Centers for Medicare & Medicaid Services. Download the templates in the Forms and References section of the Provider Library on Health Net's provider portal at **provider.healthnetcalifornia.com** > *Provider Library* under Quick Links or go directly to providerlibrary.healthnetcalifornia.com.

Template	H-contract	Product
Medicare Provider Termination Notification Template-MA H0562	H0562	Medicare Advantage
Medicare Provider Termination Notification Template-DSNP H3561	H3561	Dual Special Needs Plans: • Wellcare Dual Align • Wellcare CalViva Dual Align • Wellcare Dual Liberty

3.7 Confidentiality Standards

Health Net expects mental health practitioners to maintain client confidentiality under applicable state and federal laws as applicable to client/therapist privilege, mandated child and

elder abuse reporting requirements, and disclosure of records.

Standards for handling of confidential information at practitioner office sites:

- Practitioners should release treatment records only in accordance with a court order, subpoena, or statute.
- Practitioners should assure that any such request for records be legally obtained.
- Practitioner office staff should be trained regarding the necessity for signed authorization for release of information prior to any disclosure of confidential information, aside from exceptions specified in state and federal laws.
- Practitioners should limit access to treatment records.
- Practitioners should have a policy/procedure for:
    - Assuring confidentiality where records are stored electronically.
    - Assuring confidentiality where records are transmitted electronically.
    - Assuring confidential transmission of patient information by fax.
    - Assuring confidentiality of records delivered through mail or delivery services.
- Practitioner office staff should sign a confidentiality agreement, which should be kept on file in the practitioner's office.
- Treatment records must be locked when not in use. Treatment record storage locations must be secure and accessed only by approved personnel.
- Purging of treatment records must be done according to state statute, and in a manner, which maintains client confidentiality.

Health Net informs members that information shared with Plan staff or network clinicians is confidential. Health Net will not disclose member records or information concerning services and will not disclose the fact that a member accessed services without written consent or unless otherwise required or permitted by law.

Confidentiality of Medical Records

Protected Individual

> "Protected Individual" means any adult subscriber or enrollee covered under a health plan or health insurance policy or a minor subscriber or enrollee who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code."

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. A provider shall permit a Protected Individual to request, and shall accommodate requests for, confidential communication in the form and format requested by the Protected Individual, if it is readily producible in the requested form and format, or at alternative locations or addresses. 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. For Protected Individuals who have not designated an alternative mailing address, the Plan is required to send the communications to the address or phone number on file in the name of the Protected Individual. 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.

Effective July 1, 2022, Assembly Bill 1184, 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 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 Protected Individual’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 communications) regarding a Protected Individual'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 Plan is required to send the communications to the address or phone number on file in the name of the Protected Individual.
- Confidential communication includes:
    - Bills and attempts to collect payment.
    - A notice of adverse benefits determinations.
    - An explanation of benefits notice.
    - A plan's request for additional information regarding a claim.
    - A notice of a contested claim.
    - The name and address of a provider, description of services provided, and other information related to a visit.
    - Any written, oral, or electronic communication from a plan that contains protected health information.

Agencies Must be Authorized to Receive Medical Records

The relationship and communication between a participating provider and member is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and protected health information (PHI), whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

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:

- 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 phone.
- Demands made by subpoena duces tecum.
- Timely transfer of medical records to ensure continuity of care when a 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.

3.8 Untoward Events

Practitioners are obligated to report to Health Net the occurrence of Untoward Events experienced by a member. Untoward events include but are not limited to 1) Completed or nearly lethal suicide or homicide; and 2) Fatal or nearly fatal medication or ECT complications.

Health Net will conduct a quality review of all Untoward Events brought to its attention. Practitioners should contact the Mental Health Benefits number listed on the back of the member's ID card if they become aware of such an event involving a member.

3.9 Treatment Records

Exchange of Information with Medical Delivery Systems

Behavioral health care occurs in the context of a total health care delivery system. Contracted practitioners are expected to communicate with primary care physicians (PCPs) and other medical practitioners involved in treatment of certain shared patients. Practitioners should obtain authorization from their patients to exchange such information using their own release of information forms that meets state and federal requirements.

Health Net monitors coordination of care in two ways. Health Net assesses coordination of care in two ways. First, we annually survey primary care practitioners asking them if they found behavioral health coordination information to be timely and useful. Second, we conduct an annual evaluation of behavioral health outcome measures that are dependent on coordination of care, focused on removing barriers and improving outcomes.

Health Net considers it important to have communication among practitioners when a clinical situation merits such coordination. These clinical situations include:

1) A behavioral health practitioner begins prescribing psychotropic medications or makes significant changes to the regimen.
2) A new patient reports a concurrent medical condition, a substance use disorder, and/or a major mental illness (i.e., a condition other than an adjustment disorder), or when there is a change in one of these in an established patient.
3) A PCP or other medical practitioner refers a patient to a behavioral health practitioner.
4) A behavioral health practitioner finds out that a PCP is prescribing psychotropic medications.
5) A behavioral health practitioner terminates with a patient about whom there has previously been communication with a PCP.

SECTION 4: MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Health Net is committed to providing easily accessible, high-quality services to our members. This objective is best met by establishing a mutually respectful relationship with our members that promotes privacy, effective treatment and member satisfaction. The Member Rights and Responsibilities Statement is designed to clearly outline member rights and responsibilities in this partnership. The Plan's Member Rights and Responsibilities Statement is available at

providerlibrary.healthnetcalifornia.com in the Provider Library under *Provider Manual > Member Rights and Responsibilities*.

- Member Rights and Responsibilities (Medi-Cal)
- Member Rights and Responsibilities (Commercial)
- Member Rights and Responsibilities (Medicare)

Please take a moment to review this statement. We encourage you to review the statement with members who have questions about their rights and responsibilities.

SECTION 5: NETWORK ADEQUACY AND PRACTITIONER AVAILABILITY STANDARDS

5.1 Individual Practitioners

Network Adequacy

It is Health Net's policy to develop and maintain an adequate network in number and type of individual practitioners to ensure access to all needed specialties. The network is considered adequate if all of the following criteria are met:

- There is one behavioral health physician per 5,000 covered lives, one psychologist per 2,300 covered lives, and one master's level behavioral health clinician per 1,150 covered lives. This is measured quarterly. 90% of members will have at least one practitioner of each type (psychiatrist, psychologist, Master Level clinician) within a 10-mile radius in urban locations, 25 miles in suburban locations and 15-miles or 30 minutes in rural locations.
- Standards for ABA providers are as follows:
    - 80% of members will have at least one Behavioral Analyst within 30 miles or 60 minutes.
    - 80% of members will have at least two Behavioral Technicians within 30 miles or 60 minutes in urban and suburban locations and 60 miles in rural locations.
- The adequacy of the network is assessed and monitored on a quarterly basis, and summaries are reported to Health Net's Access Workgroup and Network Access & Availability Governance Meeting.

Practitioner Availability

Per contract with Health Net, practitioners should be available and accessible to members during reasonable hours of operation, with provision for after-hour services, if applicable. Practitioner information regarding hours of operation is collected every three years via Health Net's practitioner application for re-credentialing. Practitioners must notify Health Net of any changes in their hours of operation or lapses in their availability to see Health Net members. Health Net expects practitioners to return phone calls from members referred by Health Net (for routine referrals) within two (2) business days.

Health Net's standards for practitioner appointment accessibility are as follows:

- For Emergent appointments* clients should be seen within 6 hours of referral.
- For Urgent situations, members should be seen within 48 hours of referral.

- For Routine situations, members should be seen within 10 business days of referral to a non-physician mental health provider or a substance use disorder provider, and within 15 business days of referral to a physician/psychiatrist.
- For Routine follow-up appointments with a non-physician mental health provider or a substance use disorder provider, members should be seen within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. The waiting time for follow-up appointments may be extended if the practitioner has determined and noted in the medical record that a longer waiting time will not have a detrimental impact on the health of the member.

*In the event of a non- life-threatening emergency, practitioners are also expected to refer members to the emergency department or a crisis center if the practitioner cannot see the member within six hours.

Members who cannot schedule a routine appointment within 10 business days are given a re-referral to another practitioner. Please see Section 6.2 of this manual for more information on re-referrals.

5.2 No New Referral Periods

Practitioners are required to notify Health Net when they are not available for appointments. Practitioners may place themselves in a "no referral" hold status for a set period of time without jeopardizing their overall network status. "No referral" is set up for practitioners for the following reasons:

- Vacation
- Personal leave
- Full practice
- Other personal reasons

Practitioners can contact Provider Services at 844-966-0298 to set up a "no referral" period. Practitioners must have a start and end date indicating when they will be available again for referrals. A "no referral" period will end automatically on the set end date.

5.3 Facility Providers

Network Adequacy

It is Health Net's policy to develop and maintain an adequate network of facility providers to ensure access to all needed levels of care. The network is considered adequate if 95% of members have at least one facility providing inpatient levels of care for all age groups within 30 miles of each member in urban locations, 40 miles in suburban locations and 60 miles in rural locations. The adequacy of the network is assessed on a quarterly or bi-annual basis and reviewed by Health Net's Quality Improvement/Health Equity Committees.

Facility Access and Availability

Per 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 re-credentialing. Facilities

must notify Health Net of any changes in their hours of operation or lapses in accessibility availability as needed.

SECTION 6: MEMBER ACCESS TO PRACTITIONERS

6.1 Provider Searches

Members can access a listing of practitioners in their area by using the *ProviderSearch* tool at www.healthnet.com or calling our 24-hour access line to obtain assistance locating a practitioner. Health Net maintains a practitioner database with complete demographic information, licensure, practitioner self- ratings on clinical specialties, and geographical areas served.

6.2 Re-referrals

A "re-referral" is an additional referral given at the request of a member who wishes to change practitioners. Health Net can issue a re-referral if service from the initial referral or former referral are not yet completed. Requests for re-referral may be administrative or clinical in nature. Re-referrals will be granted regardless of whether or not a patient has contacted or seen the formerly referred practitioner.

6.3 Urgent, Emergent and Routine Referrals

Life-threatening Emergent refers to those referrals for service which require immediate evaluation.
Emergent refers to those referrals for service which require evaluation within six hours.
Urgent refers to those referrals for service which require evaluation by a licensed mental health professional within 48 hours.

Routine refers to those referrals for service requiring evaluation by a licensed mental professional within 10 business (14 calendar) days or a psychiatrist within 15 business days.

6.4 Transportation for Medi-Cal Members

Medi-Cal members are entitled to non-medical transportation (NMT) and non-emergency medical transportation (NEMT) benefits. Modivcare™ is Health Net's capitated provider for all covered non-emergency medical transportation (NEMT) and non-medical transportation (NMT) services for members assigned to a direct network provider or to shared-risk participating physician groups (PPGs). Shared-risk PPGs are PPGs that are delegated for utilization management but not financially at risk for transportation services. 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 the PPG or hospital may be liable. For members assigned to Dual Risk PPGs, please refer to the section below. For all NEMT services, a Physician Certification Statement (PCS) form must be submitted to Health Net's Care Ride Unit via fax to 833-701-0051 to obtain prior authorization.

Health Net is responsible for NMT to Medi-Cal services, including services that are carved-out, including but not limited to dental services, specialty mental health services and pharmacy services. Members are instructed to contact the Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) to request NMT services.

Dual-risk PPGs and hospitals

PPGs or hospitals that have risk for NEMT in the Division of Financial Responsibility (DOFR) must authorize and coordinate with their transportation provider for medically necessary services in a timely manner. Failure to do so will result in the plan approving and arranging the transportation and processing a capitation payment deduction. A Physician Certification Statement (PCS) form is required for all NEMT services. A PCS process must be followed to collect the PCS form and arrange NEMT services.

Participating physician groups and hospitals that have risk for NEMT in the Division of Financial Responsibility (DOFR) must authorize and coordinate with their transportation provider to ensure Medi-Cal members have 24-hour access to NEMT to a pharmacy or urgent care facility that is open 24 hours a day.

Health Net provides NMT through Modivcare for medically necessary covered services and all Medi-Cal covered services.

Coverage Requirements

NEMT services are covered when the member's condition is such that ordinary means of transportation are medically inadvisable. Such transportation is covered only for the purpose of obtaining needed Health Net-covered service. Coverage is limited to the least costly medical transportation available to adequately meet the member's medical needs. All non-emergency medical transportation (NEMT) requires a Physician Certification Statement (PCS).

Ground NEMT is authorized by the Care Ride Unit (ambulance, ambulatory door-to-door [needs assistance and/or using walker/cane/crutches], gurney/stretcher, wheelchair)

A PCS form is required before NEMT can be provided, therefore, it is very important for ordering providers to return the completed and signed form.

NMT services are covered for members to obtain medically necessary Medi-Cal services, including carve out services, including but not limited to, specialty mental health, substance use disorder, pharmacy, dental, and any other benefits covered by FFS Medi-Cal. Non-medical transportation (NMT) is available upon request by contacting Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

NEMT and NMT services include transportation for the member and one attendant, such as a parent, guardian or spouse, and must be requested at the time of the initial transportation arrangement.

With written consent of a parent or guardian, NEMT and NMT may be arranged for a minor under age 18 who is unaccompanied by a parent or guardian. Health Net provides transportation services for unaccompanied minors under age 18 when state or federal law does not require parental consent for the minor's services. All necessary written consent forms, such as Consent for Minors to Travel without an Escort Form, must be received prior to arranging transportation for an unaccompanied minor and must be provided to Health Net.

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT) includes ambulances, wheelchair vans and gurney vans and is provided when medically necessary and the patient is not ambulatory.

NEMT is a covered Medi-Cal benefit when the member needs to obtain medically necessary covered services and when prescribed in writing via the PCS form signed by a physician, physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), dentist, podiatrist, or mental health or substance use disorder provider. NEMT under Medi-Cal is covered only when the patient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated. Additionally, NEMT is covered for patients who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (ambulatory door to door). This includes door-to-door assistance for all members receiving NEMT services.

The physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or to be transported by public or private vehicles. NEMT may be authorized for visits up to 12 months in advance. A new PCS form is required every 12 months if NEMT is continued to be utilized.

NEMT necessary to obtain medical services is covered subject to the written authorization of a licensed practitioner consistent with their scope of practice. Additionally, if the non-physician medical practitioner is under the supervision of a physician, then the ability to authorize NEMT also must have been delegated by the supervising physician through a standard written agreement.

Physicians, dentists, podiatrists, PAs, NPs, CNMs, mental health or substance use disorder providers may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the Welfare and Institutions Code (W I Code).

The NEMT modalities, in accordance with the Medi-Cal Provider Manual, are:

- NEMT ambulance services which include:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers: 1) from an acute care facility to another acute care facility, immediately following an inpatient stay at the acute level of care, 2) to a skilled nursing facility or 3) to a licensed intermediate care facility.

- Litter van services, when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:
    - The member must be transported in a prone or supine position because the member is incapable of sitting for the period of time needed for transport.
    - Specialized safety equipment is required over and above that which is normally available in passenger cars, taxi cabs or other forms of public conveyance.
- Wheelchair van services, when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - The member is incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
    - Members who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (ambulatory door to door).
    - The member must be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
    - Specialized safety equipment is required over and above that which is normally available in passenger cars, taxicabs or other forms of public conveyance.
- NEMT by air (requires Health Net authorization and Letter of Agreement) only under the following conditions:
    - Transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible.

Physician Certification Statement Form - Request for Transportation

Use the Physician Certification Statement Form – Request for Transportation – Health Net, Physician Certification Statement Form – Request for Transportation – CalViva Health or Physician Certification Statement Form – Request for Transportation – Community Health Plan of Imperial Valley to document the specific transportation restrictions of a member due to a medical condition, and request non-emergency medical transportation (NEMT) for Medi-Cal members. A physician certification statement (PCS) form is not required for non-medical transportation (NMT). Providers who may complete and sign the PCS form include:

- Physician
- Dentist
- Podiatrist
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Certified nurse midwives (CNMs)
- Mental health or substance use disorder providers

Non-Medical Transportation

Modivcare can also arrange non-medical transportation (NMT), including rideshare, passenger car, taxi or other forms of public/private conveyances for certain ambulatory members needing transportation assistance when services are covered or for any Medi-Cal covered service, as follows:

NMT includes transportation for medically necessary appointments or for any Medi-Cal covered service, and may be provided by rideshare, passenger car/sedan, taxicab, paratransit, such as Access, or fixed route transportation, such as a bus, and mileage reimbursement.

- Passenger car/sedan, taxi (ambulatory curb-to-curb): Member is ambulatory and can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus or train (curb-to-curb).
- Rideshare, passenger car/sedan (ambulatory door-to-door): Member is ambulatory and can walk but requires driver assistance from residence to the medical appointment. Member may use:
- Wheelchair, able to transfer from a folding wheelchair without assistance. Note, if assistance is required, choose wheelchair van under NEMT.
- Walker.
- Cane.
- Crutches.
- Paratransit services: Member is ambulatory and can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus (curb-to-curb).
- Mass transit: Member is ambulatory and is able to use public transportation and may be medically able to walk up to a half mile to a bus stop (curb-to-curb).
- Mileage reimbursement: Member is ambulatory and has access to other means of transportation such as a working vehicle in the home, family member or neighbor. Member may request mileage reimbursement at the time the trip is scheduled (curb-to-curb).

NMT services include: round-trip transportation for a member by rideshare, passenger car, taxicab, or any other form of public or private conveyance (private vehicle), as well as mileage reimbursement (at the time transportation is arranged), bus passes, taxi vouchers, or train tickets for medical purposes.

Round-trip NMT is available for the following:

- Medically necessary covered services
- Members picking up drug prescriptions
- Members picking up medical supplies, prosthetics, orthotics, and other equipment
- Dental services
- Mental health services
- Substance abuse services
- All Medi-Cal covered services

Ground Emergency Medical Transportation (GEMT)

Participating physician groups (PPGs) and hospitals must submit a list of their contracted ground emergency medical transportation (GEMT) providers annually. This applies to Medi-Cal providers contracted under a global and dual risk arrangement. The list is due annually no later than March 31. The list will help identify non-contracted GEMT providers for automated payments that meet the requirements under the Department of Health Care Services' Public Provider Ground Emergency Medical Transport (PP-GEMT) and GEMT quality assurance fee (QAF) programs. At a minimum, include the following information on the list:

- Provider name.
- Provider type (PPG or Hospital).
- Risk type (Dual or Global).
- GEMT provider name.
- GEMT National Provider Identifier (NPI) number.

PPGs and hospitals can send their list to their assigned Provider Relations & Contracting Specialist (PRCS).

Modivcare

HMO and HSP
Non-emergency transportation services are arranged through Modivcare™ 24 hours a day, 7 days a week.

For HMO and HSP:
866-842-0675
Fax: 800-762-1777

HMO and HSP

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 one to four hours to pick up a member, depending on provider availability
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 following table 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 one 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 one to four hours to pick up a member, depending on provider availability
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance (Where's my Ride? line) and hospital discharges	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week
Modivcare Contact Information	

FORM OF CONTACT	CONTACT INFORMATION
Toll-free telephone numbers	**Submit a Physician Certification Statement (PCS) form to the Health Net Care Ride Unit via fax to 833-701-0051 to obtain authorization before contacting Modivcare for scheduling.** Health Net Care Ride Unit: Phone: 833-236-9695 Fax: 833-701-0051 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 five 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.

SECTION 7: MEMBER ELIGIBILITY

Routine outpatient therapy and medication management sessions do not require pre-authorization. If the eligibility status cannot be determined during the initial call, Health Net personnel will not approve the service. Clinically emergent or urgent care may be arranged and delivered during the validation process; with the understanding that the member is responsible for all claims should eligibility be absent. Health Net will pay for one outpatient emergent or urgent session for patients if Health Net arranges the session and the service is delivered within 48 hours from the time of the initial call. Health Net will inform the member when his or her eligibility status is determined.

Eligibility status is subject to change for a variety of reasons (i.e., termination of employment, elective change of benefit plan). Practitioners should require that their patients advise them of any eligibility changes and monitor their patients' eligibility as a good business practice.

Practitioners can call Member Services (listed on the back of the member's ID card) if they have questions about eligibility status. Practitioners are responsible for reimbursing Health Net for payments made for services rendered to ineligible members.

SECTION 8: LEVEL OF CARE AND TREATMENT CRITERIA

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

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 Early Childhood Service Intensity Instrument criteria for all mental health medical necessity determinations and level of care placement decisions. For substance use disorder utilization management Health Net uses American Society of Addiction Medicine (ASAM) criteria. 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 are applying 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 contacting:

For providers:
844-966-0298

For members:
Call the specific number listed on the back of the member's ID card.

SECTION 9: UTILIZATION MANAGEMENT – OUTPATIENT SERVICES

9.1 General Policies for Outpatient Services

Outpatient treatment as defined by Health Net, is limited to office and outpatient clinic visits. Services such as partial hospitalization programs, day treatment, and intensive outpatient programs are categorized by Health Net as Higher Levels of Care (HLOC).

Authorization

Health Net does not require authorization for routine 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 some benefit plans. *Prior authorization is required for psychological and neuropsychological testing.* Authorization requests should be made by phone or fax Utilization Manager.

Prior authorization is also required for Applied Behavioral Analysis (ABA) Services.

Certain services for American Indian members **do not** require authorization, including:

- An American Indian member can obtain covered services from an out-of-network Indian health care provider without requiring a referral from a network primary care provider (PCP) or prior authorization.
- Indian health care providers, whether in the Plan's network or out-of-network, can provide referrals directly to network providers without a referral from a network PCP or prior authorization. An American Indian member may receive services from an out-of-network Indian health care provider even if there are in-network Indian health care providers available.

9.2 Management of Outpatient Services

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 r 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, the 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 and Consent for Treatment; Consent For Release of Information

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 are 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.

SECTION 10: UTILIZATION MANAGEMENT - HIGHER LEVELS OF CARE

10.1 General Policies

This section describes authorization for higher levels of care (inpatient psychiatric, residential treatment, partial hospitalization, structured 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 provides 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 in 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 Manager to answer the question, "where and how can this member be treated safely and most effectively in an environment that will promote optimal functioning."

Precertification

Health Net has licensed clinical staff available 24 hours a day, seven days a week for precertification of acute inpatient care. Patient care is pre-certified when a treating practitioner or facility provides initial clinical information and requests authorization PRIOR to admission. If authorization prior to admission cannot be obtained, Health Net requires that facilities submit requests for authorization to Health Net within 24 hours of admission to any higher level of care treatment service. These include mental health and substance use disorder inpatient/acute detox, residential treatment, partial hospitalization and intensive outpatient programs. Barring extenuating circumstances, failure to request authorization within 24 hours of admission will result in denial of authorization.

Initial Authorization

Health Net will authorize admission to higher levels of care based on medical necessity, appropriateness of treatment plan, and whether requested services are a covered benefit.

Concurrent Review

Concurrent review of Higher Levels of Care is conducted by a Utilization Manager to determine if the proposed continued treatment or services are: (1) medically necessary, (2) appropriate to the particular patient, and (3) covered under the health plan.

Noncertification

All requests for services that do not meet *Health Net Level of Care Criteria and Medical Necessity Guidelines*, as described herein, or where medical necessity is questionable or unclear, must be reviewed by a Health Net medical director.

10.2 Procedures

Precertification

1. Facility provider must call the Health Net number and request precertification.
2. Health Net Utilization Manager conduct precertification reviews according to the following guidelines:
    - The Utilization Manager assess the patient's clinical presentation according to the medical necessity guidelines for the specific care setting, plan type, and intensity of service that is being proposed. This assessment includes the patient's presenting problem, mental status, current diagnosis, previous psychiatric/substance abuse treatment and relevant psychosocial factors.
    - If medical necessity criteria for that level of care are met, then the facility provider of care is given the appropriate verbal authorization. If the precertification occurs during non- regular business hours, the authorization is given "pending eligibility verification" and the facility provider is instructed to admit the patient to the proposed care setting, but to then contact Health Net during regular business hours for eligibility verification.
    - If medical necessity criteria are not met, then the facility provider is notified verbally, and an alternative care plan or setting is discussed. If agreement is reached on an alternative care plan or setting, written confirmation of this agreement is provided. If the plan or setting cannot be agreed upon, the Utilization Manager explains the denial process to the provider and refers the case to a Health Net medical director for review.

Initial Authorization

1. Facility providers initiate request for authorization for all higher levels of care by phone.
2. Health Net Utilization Manager review requests for medical necessity and decide upon the most appropriate level of care based on medical necessity criteria.
3. If the case does not appear to meet medical necessity criteria for the level of care requested, the Utilization Manager will refer the case for Health Net medical director review.

4. If the medical director denies authorization, refer to the non-certification procedure.
5. Once authorization is established, the Utilization Manager notifies the requesting facility of the decision and sets a date for the concurrent review.
6. The Utilization Manager generates an authorization verification letter to be mailed to provider and patient.

Concurrent Review

1. The attending physician or facility utilization review staff calls the Health Net Utilization Manager on the agreed upon review date and provides and verifies the concurrent review information.
2. The Utilization Manager obtains all 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

    Providers must notify the Health Net Utilization Manager on the same day that the member was 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 stepdown care, and member's updated contact information (i.e., address, phone number).
3. The Utilization Manager reviews clinical data and authorizes additional days if medical necessity criteria for continued stay are met.
    - If medical necessity criteria for continuing stay are not met for the level of care requested, the Utilization Manager will review the request with a Health Net medical director.
    - If the medical director denies authorization, refer to the non-certification procedure.
    - The Utilization Manager documents clinical appropriateness.
    - The Utilization Manager reviews with a clinical manager and/or a medical director when any aspect of the treatment plan is unclear and/or is in question.

Noncertification

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

1. The Health Net Utilization Manager receives requests for authorization by phone from the clinical contact at the facility or program.
2. Administrative denials (based on exhaustion of benefits, lack of pre-authorization, etc.) do not require a Health Net medical director review.
3. When medical necessity criteria do not appear to be met, the Utilization Manager

presents the case to the medical director for review. In the case of clinical denials, the facility is notified by the Utilization Manager that they can request a peer-to-peer discussion with the peer reviewer who originally denied the authorization. If the decision then remains unacceptable, 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 made by phone immediately. 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 the case of inpatient treatment services where the member is still hospitalized, a practitioner who would like 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.

10.3 Timeliness Standards for Utilization Management

Decision Making Definitions:

Non-Urgent, Pre-Service Decision: 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 does not meet the criteria for an urgent decision listed below.

Post-Service Decision: Any review for care or services that have already been received and completed, but not previously reviewed and authorized.

Post-Stabilization Services: 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.

Psychiatric Emergency Medical Condition: A "psychiatric emergency medical condition is defined as a mental disorder manifested by acute symptoms that render the patient: 1) an immediate danger to himself, herself, or others; or 2) immediately unable to provide for, or utilize, food, shelter, or clothing. (H&S Code 1317.1 [k]) Psychiatric emergencies may present independently or concurrent with a physical emergency medical condition.

Urgent Decision: Any request with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain the maximum function, based on a subjective standard that focuses on the belief of the existence of an Emergency Medical Condition or Psychiatric Emergency Medical Condition that requires immediate medical and/or psychiatric treatment; or

2. 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 Concurrent Review Decision: Any review for treatment which has already begun*. This determination is always 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 Urgent Decision below, default to Non-Urgent Pre-Service category.

** For Medicare, treatment that has begun within one (1) business day can be considered Pre-Service Urgent.*

Urgent Pre-Service Decision: 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 meets the criteria for an urgent decision listed above.

For Cases Where All Required Information is Received at the Time of the Initial Decision

Type of Request	**Decision**	**Oral Notification of Approval and Denial to Practitioner and Member**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre- Service	Within 24 hours of receipt of the request.	Within 24 hours of receipt of the request.	Within 72 hours of receipt of the request.
Non-Urgent Pre-Service	Within 5 business days of receipt of the request.	Within 24 hours of making the decision.	Within 2 business days of making the decision.
Urgent Concurrent	Within 24 hours of receipt of the request.	Within 24 hours of receipt of the request.	Within 24 hours of receipt of the request.
Post- Service	Within 30 calendar days of receipt of the request.	Not applicable	Within 30 calendar days of receipt of the request.

Note: Requests Received after business hours:

NCQA counts the time from the date when Health Net receives the request, whether or not it is during business hours. Non urgent requests may be processed during the next business day.

For Cases Where All Required Information is Not Received at the Time of the Initial Decision

Type of Request	Decision
Urgent Pre-Service – Notify member and practitioner within 24 hours of receipt of request and provide 48 hours for submission of requested information.	If additional information is received, complete or not, decision must be made within 24 hours of receipt of information.
	If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available.
Non-Urgent Pre-Service	Determination of the extension must be made within 5 days from the initial request. If additional information is received, complete or not, decision must be made within 5 business days of receipt of information.
	If information is not received within the 45 calendar days, a decision must be made with the information that is available within an additional 15 calendar days.
Post-Service - Notify member and provider within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.	*Additional information received or incomplete* If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.

For Cases Where Expert Consultation is Required to Make the Initial Decision

Type of Request	Notification
Non-Urgent Pre-Service	If a consultation is required by an expert reviewer, upon the expiration of the 5 business days or as soon as Health Net becomes aware that the 5 business day 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 15 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).

For Medicare Cases

Type of Request	Decision
Medicare Standard (pre- service or concurrent)	Within 14 calendar days of receipt of request
Medicare Expedited (pre- service or concurrent)	Within 72 hours of receipt of request
Medicare Post Service	N/A. Provider must submit a claim with records. Claims Department will handle with PSR

Health Net may extend the time frames for expedited requests up to 72 hours, and standard requests up to 14 calendar days, ***only*** if member requests or the provider/organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.

What requires approval

The prior authorization list of services is reviewed annually to determine the appropriateness for inclusion and potential deletions to the list. Our team of medical directors consists of medical and behavioral health clinical leadership.

When deciding what benefits will be subject to prior authorization, the team evaluates the current list of services using established factors. Based on the application of these factors (e.g., safety, clinical efficacy, length of treatment) authorization may be required for some behavioral health /substance use disorder benefits. These factors are backed by recognized medical literature and professional

standards. Prior authorization will apply for only those services/procedures which meet one or more of the factors identified by the team and for which the quality of care can be favorably influenced by medical necessity or appropriateness review.

Services currently requiring prior authorization (2024)

Inpatient:

- Inpatient behavioral health
- Inpatient detoxification
- Electroconvulsive therapy (ECT)
- Residential treatment
- Inpatient rehabilitation
- ECT Professional (no authorization required, but requires facility authorization)
- Psychological testing
- Neuropsychological testing

Outpatient Other:

- Psychological testing
- Neuropsychological testing
- Outpatient ECT
- Transcranial magnetic stimulation (TMS)
- Applied behavioral analysis (ABA)
- Treatment plan/reports (tied to ABA)
- Partial hospital program or day hospital (PHP)
- Half-day partial hospital
- Intensive outpatient program (IOP)

10.4 Requests for Authorization for Post-Stabilization Care

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 member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for inpatient post-stabilization care. When a member is stabilized after emergency services but needs continued care before safely being discharged or transferred, the health care provider must request an authorization for 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 the Plan 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 or facility admissions office at 844-966-0298.

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 and substance use disorder treatment that includes behavioral health crisis services provided to a member by a 988 crisis call center, mobile crisis team or other behavioral health crisis services providers, regardless of whether that provider or facility is in network or out of network. Hospitals must call 844-966-0298 to request authorization for members' post-stabilization care once they are deemed stable but require facility-based care.

- **Medi-Cal members:** For post-stabilization care related to behavioral health for Medi-Cal members, Health Net oversees medical evaluation, stabilization and initial care. However, ongoing care in a facility following a behavioral health emergency falls under the responsibility of County Mental Health Plans. To ensure continuity of care, please contact your County Mental Health Plan for authorization of all facility-based services. They will coordinate and manage continued care once the member has been stabilized and is ready for transition.

  County Mental Health Plan information is available through the Department of Health Care Services. The Plan will coordinate with the County Mental Health Plan to transition the member once appropriate.

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 the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is considered authorized. This applies to a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Failure to request post-stabilization authorization

The Plan 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.

Additional step for CCS-eligible conditions (Medi-Cal members)

If a patient's Plan identification (ID) card indicates enrollment through Medi-Cal, the member is under age 21, and services are related to a California Children's Services (CCS)-eligible condition, the hospital must call the hospital or facility admissions office at 844-966-0298 using the procedure described above. After that, the hospital must immediately seek authorization for treatment from CCS by faxing a Service Authorization Request with medical records to the local county CCS office. If your facility is not CCS-approved, the member must transfer to a CCS-approved facility.
The Plan coordinates with hospitals that seek CCS authorization for treatment but does not provide authorization for services for which CCS is financially responsible.

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.

SECTION 11: QUALITY IMPROVEMENT

11.1 Member Surveys

To ensure understanding of members' ability to access services, efficiently navigate Health Net processes, and receive effective behavioral health service, Health Net administers a member survey instrument. This instrument also assesses members' level of satisfaction with Health Net, as well as identifying their perceived value of services and any improvements they identify from services they have obtained. The results from these surveys are used to both inform interventions to improve Health Net's processes and systems, as well as assess our network of providers to ensure optimal practitioner performance.

11.2 Provider Surveys

Provider shall participate in and assist Health Net with any review conducted by a regulatory agency or any accreditation survey or study.

11.3 Focused Studies

Health Net has comprehensive programs for engaging in quality improvement projects. These projects use baseline performance data to identify opportunities for improvement that in turn undergo interventions to improve the area being studied. Re-measurement of performance data then occurs to ensure improvements have been made. When improvement is not readily detected, additional interventions and investigation into underlying causes of the lack of progress are then undertaken. The projects can target specific conditions (such as ADHD or depression) or service events that a multitude of different members may undergo (such as discharge or transition to/from practitioners). Each year, we include a number of focused studies in our work plan. Practitioners are invited to submit ideas for topics for focused studies; please direct suggestions to the Quality Management Department.

11.4 Member Complaints

Member Complaints

A member may file a complaint about the Plan either verbally or in writing. Member complaints may be filed with any staff member. Complaints are taken very seriously, and all are investigated by Health Net. Investigation includes discussing the complaint with the member and with the practitioner. The outcome of complaint investigation varies, depending on the nature of the complaint. Our standard is that all formal complaints be resolved within 30 days.

If members should wish to submit a grievance online, they can go to the Health Net website at https://www.healthnet.com/content/healthnet/en_us/members/appeals-and-grievances to find information and forms. In addition, a member may find information and an Independent Medical Review (IMR) form in various languages on the website of the California Department of Managed Health Care (DMHC) at www.dmhc.ca.gov.

California Department of Managed Health Care

The following is the DMHC notification to members that accompanies any adverse determination or complaint response:

> 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 **[insert member-specific phone 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 **(888-466-2219)** and a **TDD line (877-688-9891)** for the hearing and speech impaired. The department's website at **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Emergency Grievances: When Health Net has notice of a case involving 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, Health Net provides the following: (a) immediate notification to the member of their right to notify DMHC of the grievance, and (b) no later than three days from receipt of the notice of such grievance request, a written statement to the member and DMHC on the disposition or the pending status of the grievance.

11.5 Potential Quality Issues

A reported potential or suspected deviation from expected performance; clinical outcome which cannot be determined or justified without additional evaluation and review. A PQI is non-member generated. Health Net defines a PQI as an identified or discovered event by a Health Net associate and/or the plans' providers and practitioners that are confidentially reported through the plans' PQI referral process. PQIs are initially reviewed by a Clinician, and referred to a Medical Director. PQI's may also originate from the provider preventable conditions (PPC) reporting process, which includes health care acquired conditions (HACs) and other provider preventable conditions (OPPCs.)

11.6 Member Appeals and Provider Disputes Utilization Management Decisions

Health Net's appeals process has been established to offer members the opportunity to appeal decisions to deny coverage or payment. Health Net's Provider Dispute Resolution process has been established to also give practitioners and facility providers rights to appeal (aka dispute) utilization management decisions for both medical necessity or benefit coverage reasons. Medical necessity provider disputes are reviewed by a peer reviewer other than the Health Net reviewer who made the initial determination not to authorize the services. Please refer to the Section on Provider Dispute Resolution, section 12.4, for full details of the provider dispute process.

Member Appeal Categories

Urgent Member Appeal: The member has a right to an urgent appeal whenever there is an imminent danger of grave injury or death or if the treating psychiatrist/clinician believes that a life-threatening urgency exists. In this case, the treating practitioner or attending physician is presumed to be requesting urgent appeal on behalf of a member. Such urgent appeals are completed as soon as possible but in no event later than 72 hours after the appeal request is received.

Pre-Service Appeal: The member has a right to a pre-service appeal whenever they are awaiting treatment or are in treatment and wish to continue. Practitioners/facility providers can, with the member's permission, appeal on their behalf. Pre-service appeals are resolved as expeditiously as the clinical circumstances warrant, (generally within 1-3 calendar days), but in no event more than 30 calendar days from the date of the appeal request. Members or providers have the right to submit, if they wish, any information or collateral material relevant to the appeal either by phone, fax or in writing. This member appeal is completed by a peer reviewer other than the one who made the initial decision not to authorize services.

Post Service Member Appeal: Member appeals that are received, either verbally or in writing, after services have been rendered are acknowledged in writing within five (5) calendar

days of receipt and are resolved within 30 calendar days. Members or providers have the right to submit, if they wish, any information or collateral material relevant to the appeal either by phone, fax or in writing. This member appeal is completed by a peer reviewer other than the one who made the initial decision not to authorize services.

Details about the availability of external independent medical review as well as submission directions are provided with all applicable denial and resolution letters.

You can file an expedited or urgent appeal if your patient:

- Is currently receiving or was prescribed to receive treatment; and
- Has an "urgent" situation. Urgent means a medical provider believes a delay in treatment could seriously jeopardize the patient's life or overall health, affect the patient's ability to regain maximum function, or subject the patient to severe and intolerable pain; OR
- Has an issue related to admission, availability of care, continued stay, or a health care service received on an emergency basis and has not been discharged.

You cannot file an expedited or urgent appeal if your patient:

- Already received the treatment and is disputing the denied claim; or
- The patient's situation is not urgent.

Who decides if the situation is urgent?

- A medical provider with knowledge of the patient's medical condition or Health Net's medical director will decide if the situation is urgent or not.

How do you file an expedited or urgent appeal?

- You or your patient may file an expedited or urgent appeal verbally by calling 844-966-0298.

Health Net will respond as soon as possible, but no longer than 72 hours. Health Net will deliver our response verbally, and either Health Net or the Insurer will issue it in writing no later than 72 hours after the request.

The patient may even have the option to request an independent medical review before Health Net's internal review is complete.

If you need to file an urgent appeal, we suggest the patient, the patient's authorized representative, or the provider call 844-966-0298 immediately.

How do you file a non-expedited or non- urgent appeal?

You may file a non-expedited or non-urgent appeal through the provider dispute resolution process in writing to:

- **Medicare**
  P.O. Box 9030
  Farmington, MO 63640-9030
- **Commercial**
  P.O. Box 989882
  West Sacramento, CA 95798-9882

- **IFP**
  P.O. Box 9040
  Farmington, MO 63640-9040
- **Medi-Cal**
  P.O. Box 989882
  West Sacramento, CA 95798-9882

Peer-to-Peer Consultation: Practitioners and facility providers have the right to a direct conversation with the peer reviewer who made a denial determination, whether pre- or post-service, to discuss the reasons for the decision not to authorize services prior to filing a dispute/appeal.

Provider Dispute: Standard written dispute/appeal of a determination that occurs subsequent to treatment services being rendered. These disputes are to be sent in writing, along with all relevant records, for appeal review. Such requests will be acknowledged within fifteen (15) business days and resolved within forty- five (45) business days of receipt of a complete dispute. Clinical Appeals are conducted by a Health Net peer reviewer other than the one who made the initial determination not to authorize services. Peer reviewers include Health Net medical directors, physician advisors or licensed psychologists. Please reference our website at provider.healthnet.com for full details of the provider dispute process.

11.7 Quality Review

Health Net conducts peer review of cases where there has been a complaint or potential quality issue. In addition, we review practitioners whose profiles indicate potential problems. Clinical and Quality departments work collaboratively to make decisions on any corrective action to be taken regarding a practitioner.

11.8 Practitioner Satisfaction

Health Net seeks out information on practitioner satisfaction with our system. On an annual basis, we send out a Practitioner Satisfaction Survey to a sample of practitioners. The survey asks about satisfaction with specific types of staff and with processes.

11.9 Level of Care Criteria and Clinical Position Papers

Our clinical practice guideline committee considers 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 the Clinical Leadership Committee (CLC). The CLC then submits the guideline to the Medical Affairs Committee (MAC) with a recommendation that it approve the guideline. The MAC makes the final decision to approve and adopt the guideline.

We currently have the following Clinical Position Papers:

Position Statements

- 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

We currently have the following Treatment Guidelines:

Care Based 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

Hard copy of these documents may be obtained by calling 844-966-0298 or accessing the Health Net website.

11.10 Language Assistance Program (LAP)

The Health Care Language Assistance Act requires all California managed care health plans to provide language assistance and culturally sensitive services to members who are limited-English proficient (LEP).

To comply with this mandate, Health Net created the Language Assistance Program (LAP) to ensure that members with LAP are able to obtain language assistance while accessing mental health care services.

Health Net maintains ongoing administrative and financial responsibility for implementing and operating the language assistance program for members and does not delegate its obligations under language assistance regulations to its participating providers.

The Language Assistance Program includes the following:

11.6.1 Interpreter services for members with LAP are available 24 hours a day, seven days a week by calling the number on the back of the member's ID card. Language assistance includes **face-to-face, telephonic interpretation services and written translation services**.

11.6.2 Health Net provides a notice of language assistance services with vital documents to all members. Health Net will provide **translated** documents in threshold languages. Health Net will provide

interpretation in many more languages, upon request. This notice is also available to contracted providers for distribution to members upon request.

Provider LAP Compliance Requirements

11.6.3 Interpreter Services- Use qualified interpreters for members with LEP. Interpreter services are provided by Health Net at no cost to the provider or the member. You may contact the Language Assistance Services Line or Member Service to arrange interpretation services.

11.6.4 Member Complaint/Grievances Forms- Members wishing to file a grievance or complaint should call the number listed on the back of their member identification card, or access Health Net's website at provider.healthnet.com obtain complaint/grievance forms, also available in other languages.

11.6.5 Independent Medical Review Application – Locate the DMHC's Independent Medical Review (IMR) application and provide it to members upon request. This application is available in other languages on the DMHC website at http://www.dmhc.ca.gov/FileaComplaint.aspx.

11.6.6 Documentation of Language Preference – Document the member's language preference and the refusal or use of interpreter services in the member's medical record. Health Net strongly discourages the use of adult family or friends as interpreters, except in emergency situations. If, after being informed of the availability of interpreter services, the member prefers to use an adult family or friend as an interpreter, the provider must document this in the member's medical record. The use of a minor as an interpreter is only permitted in emergency situations.

11.6.7 Engage Telephonic Referral if face-to face interpreter is late – If a scheduled face-to- face interpreter fails to attend appointment within an acceptable time frame, providers are encouraged to offer the patient the choice of using a telephonic interpreter. Providers can call the number on the back of the member's ID card and a customer service agent will conference in the telephone interpreter to expedite services.

11.6.8 Notify Health Net of Language Capability Changes- Practitioners are contractually obligated to notify Health Net of any change to their practice, including changes in language abilities, 30 days prior to the effective date of such a change, by attesting to these changes via the provider portal at healthnet.com. Health Net does not track bilingual changes among office staff, however practitioners must notify us when there has been an addition/departure of a bilingual clinician from a group practice.

Additional Information

If you have additional questions regarding translation or interpretation services available to our members, contact the phone number indicated on the back of the member identification card. If you have any other questions about your network participation, please contact Provider Services at 844-966-0298.

SECTION 12: BILLING AND REIMBURSEMENT

12.1 General Policies

- As a condition of payment, practitioners must bill for outpatient services within 180 days of the date of service.
- Practitioners must collect any copayments due from Health Net members and must accept payment from Health Net as payment-in-full for covered services.
- Practitioners should submit claims with their charges however, in no event shall the rates payable under the Practitioner's *Participating Provider Agreement* (Health Net contract) exceed the amounts billed by the practitioner.
- Practitioners may not balance bill members.
- Practitioners may bill for missed or cancelled managed care appointments **only** if the member has been advised of, and has agreed to in writing, the practitioner's no-show policy.
- Practitioners must advise members in writing prior to providing excluded services that services will not be covered by Health Net and the member will be responsible for paying the practitioner directly for these services.
- Please note that you may only bill 1 session using CPT code 90791 and/or 90792 (psychiatric diagnostic interview), per patient in a 180-day period. Additional sessions billed with 90791 and/or 90792 for the same treatment episode will be denied.

The following time requirements for payment are included in the Health Net Provider Agreement:

- Health Net shall pay practitioners within 30 business days of receipt by Health Net of a completed "Clean" Claim for Covered Services (45 business days in the case of HMO claims).
- Health Net shall process all "unclean" claims within 30 business days of their being made "clean".
- A "Clean" Claim is one that is accurate, complete (i.e., inclusive of all information necessary to determine payor liability), not a claim on appeal, and not contested (i.e., not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment).

12.2 Outpatient Billing Procedures

For outpatient treatment you must submit claims electronically or bill Health Net using the CMS (HCFA)- 1500. **Health Net will only accept paper claims submitted on CMS 1500 forms that are printed in Flint OCR Red, J6983, (or exact match) ink.**

Health Net will not accept:

- Claims that are handwritten (regardless of the color of the form).
- Claims that have been photocopied.
- Forms other than the CMS 1500.

Claims submitted in the formats above will be rejected and returned to the biller.

As a condition of payment, claims must be submitted within 90 calendar days of services rendered. Claims for the Medi-Cal line of business must be submitted within 180 calendar days in order for payment to be made.

Please log into our provider portal at provider.healthnetcalifornia.com **Error! Hyperlink reference not valid.**to verify subscriber information and member eligibility before submitting claims. This will enable you to confirm that the correct information is being submitted and will help eliminate delays in processing your claim.

If you have a concern involving a claims payment issue, contact Provider Services at 844-966-0298.

Electronic Claims Submission

You can submit electronic claims directly to Health Net through **Ability (formerly MD On-Line) or Availity** using the Payer ID below:

Line of business	**Payer ID**	
	Date of Service On and After January 1, 2024	**Date of Service Prior to January 1, 2024**
Medicare	68069	22771
Individual & Family Plans – IFP (Ambetter HMO and PPO)	68069	
Commercial (Employer Group HMO/POS and PPO)	95567	
	Date of Service On and After September 1, 2024	**Date of Service Prior to September 1, 2024**
Medi-Cal	95567	22771

Health Net has partnered with Ability and Availity to allow you to submit claims at no cost (some restrictions apply). To set up an account, contact:

Ability:
888-499-5465
www.mdon-line.com

Availity:
800-282-4548
www.Availity.com

Paper Claims Submissions

Paper claims must be submitted using a CMS (HCFA)-1500 **that is printed in Flint OCR Red, J6983, (or exact match) ink.** Claims that are not submitted on this form and/or do not include all of the required information will be returned to the biller.

For claims with dates of service on and after January 1, 2024, submit paper claims to:

Medicare:

Health Net Medicare Claims
P.O. Box 9030
Farmington, MO 63640-9030

IFP:

Health Net Commercial Claims – IFP
P.O. Box 9040
Farmington, MO 63640-9040

Commercial:

Health Net Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

Medi-Cal:

For claims with dates of service on and after September 1, 2024, submit paper claims to:

Health Net Medi-Cal Claims
P.O. Box 9020
Farmington, MO 63640-9020

For claims with dates of service prior to September 1, 2024, submit paper claims to:

MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

A. Completion of CMS 1500 - Instructions

Complete claim must include:

- Correct Subscriber/Insured ID number
- Subscriber/Insured name
- Subscriber/Insured address
- Patient Name
- Patient address
- Patient Date of Birth
- Practitioner Name
- Practitioner Tax Identification Number
- Practitioner's servicing address, ZIP code and phone number
- Billing Provider address, ZIP code and phone number

- Date(s) of Service
- Diagnoses Codes
- CPT Procedure Code(s)
- CMS Place of Service Code
- Number of days or units
- Billed Charges

Definitions

- Insured: The primary holder of the insurance (typically the employee).
- Patient: The person accessing the service (may be the subscriber or a dependent of the subscriber).
- Insured ID Number: The number used by the insurance company to identify the insured person. It is printed on their insurance identification card.
- Place/Type of Service: A 2-digit code that designates where services were performed (e.g., home, hospital, office, clinic, etc.). For example, an office visit place of service code "11."
- Diagnosis Code: Represents why service is being sought.
- CPT Procedure Code: A code designating the type of service received.

The following are required fields:

- Box 1 – Indicate the type of insurance coverage applicable to this claim by checking the appropriate box. o Box 1a – Insert correct insured/ID number.
- Box 2 – Enter the patient’s name as it appears on the insurance card or benefit enrollment forms (i.e., last name, first name).
- Box 3 – Enter the patient’s date of birth in MM/DD/YYYY format. Check appropriate gender.
- Box 4 – Enter /insured name in last name, first name format (e.g., Doe, John).
- Box 5 – Enter the patient’s mailing address and phone number.
- Box 6 – Check the appropriate box for the patient’s relationship to the insured.
- Box 7 – Enter the insured’s mailing address and phone number.
- Boxes 9 through 9d –These are required if the patient is covered by more than one health plan/insurance policy.
- Box 9 – Enter the full name of the other person under whose insurance the patient is also covered. Box 9a – Enter the insured’s policy or group number.
- Box 9b – Enter the insured’s date of birth and gender.
- Box 9c – Enter the employer or school information for the subscriber. Box 9d – Enter the plan or program name for the insured’s health plan.
- Boxes 10a through 10c – Check “yes” or “no” to indicate whether employment, auto accident or other accident involvement applies to one or more of the services being billed.
- Box 12 – Enter the patient's signature to authorize release of medical information necessary to process the claim. If the patient is a minor child, a parent or legal guardian should sign. Signatures can be “signature on file” and/or computer-generated

signature.

- Box 13 – The patient's signature in this box indicates that reimbursement is to be sent to the provider of service at the address indicated in Box 33. This can be" signature on file" and/or computer-generated signature. If the insured is to be reimbursed, this box should be left BLANK. (Note: if Box 13 is left blank reimbursement will be sent to the insured, whether
- or not the insured is also the patient.) Do not put any text in this box other than the signature or "signature on file". Any text in this box may be interpreted as authorization of payment of benefits to the provider of service. If Box 29 indicates that the claim has been paid in full, the claim will be assigned to the member regardless if there is a signature in Box 13.
- Box 17 – If Box 17 is completed, the corresponding NPI # must be included in Box 17b.
- Box 21 – Enter the patient's diagnosis/condition code(s). Use the highest level of specificity of DSM-V or ICD-10-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
- o Box 24 o Column A – Date(s) of service in MM DD YY format. One date of service per line. Maximum of six dates of service per claim form. O Column B – Enter the appropriate place of service code for each service performed (e.g., 11 = office visit) o Column D – Enter the procedure or services using the current CPT-4 procedure codes. o Column E – Enter the diagnosis code reference number (as shown in Box 21) to indicate the date of service and the procedures performed. O Column F – Enter the charge for each of the listed services. O Column G – Enter the number of units. O Column I – The shaded field is used to identify what type of number is placed in 24J. O Column J – The rendering provider's NPI # belongs in the white box of 24J. The shaded box is for other identifying number the provider is allowed to submit.
- Box 25 – Enter the federal tax identification number for the treating practitioner or group. The claim will be returned if the Tax ID Number is not provided.
- Box 27 – Check appropriate box to indicate if the provider of service accepts Medicare assignment.
- Box 31 – Enter the printed/typed name and signature of provider of service, including degree/credentials.
- Box 32 – If Box 32 is completed, the corresponding NPI # must be included in Box 32b.
- Box 33 – Enter the name, group name (if applicable), licensure, address and phone number for the pay-to (billing) information. If Box 33 is completed, the corresponding NPI # must be included in Box 33b.

Claims that do not include the above information will be contested by Health Net. A remittance advice will be returned requesting completion and resubmission.

Reference guide for commonly submitted items

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

Reference guide for commonly submitted items

Form fields	Electronic	CMS-1500	UB-04
NPI	qualifier		
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
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

Reference guide for commonly submitted items

Form fields	Electronic	CMS-1500	UB-04
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

12.3 "No-Show" Policy for Outpatient Sessions

All urgent/emergent cases: Health Net will reimburse practitioners for "No Shows" at their contracted rates when we have called the practitioner to request that an urgent/emergent appointment be set up.

Routine cases (for non-Medi-Cal members): Practitioners are advised to inform members of their cancellation policy at the time of the first session. A practitioner may bill the member for their service rates for any "No Shows" beyond the first session if the member was educated about the practitioner's cancellation policy.

Missed Appointments for Medi-Cal Members

Appointments may be missed due to member cancellations or no-shows. As an Medi-Cal participating provider (practitioner), it is your responsibility to provide the best care for our valued members. It is our members' responsibility to keep their scheduled appointments. If you are experiencing a pattern of missed appointments with a member, we remind you that a Medi-Cal beneficiary may not be billed for missed or last-minute canceled appointments, regardless of your practice policy.

For members that have exhibited a pattern of missing scheduled appointments or canceling last minute, we advise you to direct the member to Member Services for assistance locating a new provider who might have more convenient appointment times and a better match. A pattern can be identified as soon as two scheduled appointments are missed or canceled at the last minute. If you direct the member to the Plan for help finding a new provider, please do not cease treatment until a new provider is confirmed. This will ensure the member has access to care in the event there is an urgent need before their first appointment with a new provider.

(Note that some benefit plans limit the amount that can be billed. You may direct questions about these plans to Member Services at the toll-free phone number printed on the patient's ID card.)

12.4 Provider Dispute Resolution

Health Net has established a provider dispute resolution process for both individual practitioners and facility providers, to ensure consistent, timely, and effective de novo review of an issue that has not been satisfactorily resolved through our regular provider customer service channels. This process is available to both contracted and non-contracted providers.

The first steps towards resolving a dispute are outlined below.

NOTE: The majority of issues with authorizations, claims can be resolved through Provider Services.

1. If you have a concern involving or regarding any of the following, please call Provider Services at 844-966-0298.
    - Claims payment issue.
    - Authorizations or access to care for a member (the member's employer group number can be requested, or can be found on the back of the member's ID card)
    - Contracting status.
2. For cases where authorization has been denied because the case does not meet medical necessity criteria, please follow the dispute resolution process below.
3. If you suspect fraud or abuse in the provision of services or submission of claims, please contact our Fraud & Abuse Hotline at 866-685-8664.

Dispute Resolution Process

If the steps outlined above do not fully resolve your concern, please use the Provider Dispute Resolution Request Form. If the dispute is for multiple, substantially similar claims, complete the spreadsheet on page 2 of the Provider Dispute Resolution Request Form.

A. Dispute Resolution Process for Contracted Providers

Definition of Contracted Provider Dispute

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; and
- 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 dispute; and
    - An enrollee's written authorization for provider to represent said enrollees.

B. Submitting a Contracted Provider Dispute

Contracted provider disputes submitted to Health Net must include the information listed in Section III.A., above, for each contracted provider dispute. To facilitate resolution, providers should use the Provider Dispute Resolution Request Form to submit the required information.

All contracted provider disputes must be sent to the attention of Provider Disputes. For disputes on claims with dates of service on and after January 1, 2024, send to the following address:

Medicare
P.O. Box 9030
Farmington, MO 63640-9030

Commercial
P.O. Box 989882
West Sacramento, CA 95798-9882

IFP
P.O. Box 9040
Farmington, MO 63640-9040

Medi-Cal
P.O. Box 989882
West Sacramento, CA 95798-9882

For disputes on claims with dates of service prior to January 1, 2024, send to the following address:

MHN Provider Appeals/Disputes
P.O. Box 989882
West Sacramento, CA 95798-9882

Time Period for Submission of Provider Disputes

Contracted provider disputes must be received by Health Net within 365 calendar days from Health Net's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute, or in the case of inaction, contracted provider disputes must be received by Health Net within 365 calendar days after Health Net's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted provider disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended contracted provider dispute, which includes the missing information, may be submitted to Health Net within thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes

Health Net will acknowledge receipt of all contracted provider disputes within fifteen (15) working days of the date of receipt by Health Net.

Status of Contracted Provider Dispute

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute or other inquiries must be directed to Provider Services at 844-966-0298.

Instructions for Filing Substantially Similar Contracted Provider Disputes

Substantially similar multiple claims, billing or contractual disputes, should be filed in batches as a single dispute, and should be submitted using the Provider Dispute Resolution Request Form.

Time Period for Resolution and Written Determination of Contracted Provider Dispute

Health Net will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments

If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, Health Net will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

Billing

Do not bill members for days denied by Health Net. Your contract does not permit it. Instead, please submit the Provider Dispute Resolution Request Form with the required information to the address listed above.

C. Non-Contracted Provider Dispute

Definition of Non-Contracted Provider Dispute

A non-contracted provider dispute is a non-contracted 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 disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID, contact information, and:

- If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Health Net to 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, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect; and
- If the non-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 dispute, and an enrollee's written authorization for provider to represent said enrollees.

Dispute Resolution Process for Non-Contracted Providers

The dispute resolution process for non-contracted providers is the same as the process for contracted providers as set forth above, **except if the case involves payment for services provided to a Medicare Advantage member. In those cases, non-contracted providers must submit their dispute within 120 days (as opposed to 365 days) and Health Net will issue a determination within 30 days (as opposed to 45 working days).**

D. Claim Overpayment

Notice of Overpayment of a Claim

If Health Net determines that it has overpaid a claim, we will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which Health Net believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice

If the provider contests Health Net’s notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to Health Net stating the basis upon which the provider believes that the claim was not overpaid. We will process the contested notice in accordance with our contracted provider dispute

resolution process described in Section III above.

No Contest

If the provider does not contest Health Net's notice of overpayment of a claim, the provider must reimburse Health Net within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

12.5 Telehealth Billing Requirement

When billing for a covered service delivered appropriately through a telehealth modality, providers must use the appropriate American Medical Association (AMA) CPT and HCPCS codes that are most descriptive for the service delivered.
For Medi-Cal members, bill for telehealth services in accordance with the DHCS Provider Manual Telehealth requirements.

For Commercial members:

- Use the normal place of service code (11, 23, etc.) – excluding FQHC/RHCs.
    - Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Pricing using the Medicare physician fee schedule will result in payment parity in either situation for commercial claims.
- Use appropriate modifiers – excluding FQHC/RHCs.
    - Modifier 95 (synchronous, interactive audio and telecommunications systems); or
    - Modifier GQ (asynchronous store and forward telecommunications systems).

For Medicare members:

- Bill in accordance with CMS requirements.
- Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Any related pricing using the Medicare physician fee schedule will apply the applicable Medicare rate for the place of service code used (facility rate for place of service "02" and non-facility rate for place of service "10") in accordance with CMS guidelines.

SECTION 13: STATE-SPECIFIC INFORMATION AND IMPORTANT REGULATIONS

13.1 LEGISLATION AND REGULATIONS IMPACTING BEHAVIORAL HEALTH PRACTITIONERS

The following are highlights of California legislation and regulations impacting behavioral health practitioners. For additional information regarding these bills, as well as full details of all California legislation impacting behavioral health practitioners, please consult the **Official California Legislative Information** website at http://leginfo.legislature.ca.gov.

SB 345: Legally Protected Health Care Activities - Reproductive Rights

The Reproductive Privacy Act guarantees individuals a fundamental right to privacy regarding their reproductive choices, preventing the state from denying or interfering with a person's right to choose or obtain an abortion before the fetus is viable or when the abortion is necessary to protect the person's life or health.[1]

Certain businesses handling medical information on sensitive services must develop security policies for data related to gender-affirming care, abortion, abortion-related services, and contraception. California law also prohibits health care providers, plans, contractors, or employers from sharing medical information for investigations or inquiries from other states or federal agencies regarding lawful abortions unless authorized by existing law.

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

State law specifically states:[1]

- **A business that electronically stores or maintains medical information on the provision of sensitive services**, including, but not limited to, on an electronic health record system or electronic medical record system, on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer, must have capabilities, policies, and procedures, on or before July 1, 2024, that enable all of the following:

  (A) **Limit user access privileges** to information systems that contain medical information related to gender affirming care, abortion and abortion-related services, and contraception only to those persons who are authorized to access specified medical information.

  (B) **Prevent the disclosure, access, transfer, transmission, or processing of medical information** related to gender-affirming care, abortion and abortion-related services, and contraception to persons and entities outside of the state of California.

  (C) **Segregate medical information** related to gender-affirming care, abortion and abortion-related services, and contraception from the rest of the patient’s record.

  (D**) Provide the ability to automatically disable access** to segregated medical information related to gender-affirming care, abortion and abortion-related services, and contraception by individuals and entities in another state.

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

Legally protected health care activity includes but is not limited to:

- Reproductive health care services,
- Gender-affirming health care services, and
- Gender-affirming mental health care services.

Sensitive services include but are not limited to:

- Services related to mental/behavioral health,
- Sexual and reproductive health,
- Sexually transmitted infections,
- Substance use disorder,
- Gender-affirming care, and
- Intimate partner violence.

How reproductive privacy affects providers and others[1]

Note these requirements:

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

Impacts of regulations on business, business partners, or members

- **Regulations prohibit healing arts boards** from denying an application for a license, or from imposing discipline on a licensee, on the basis of a civil judgment, criminal conviction or disciplinary action in another state if that judgment is based solely on the application of another state's law that interferes with a person right to receive sensitive services.
- **The practice of nurse-midwifery** includes care for common gynecologic conditions and (when certified by a physician or surgeon) to furnish or order Schedule II and III controlled substances as specified.
- **Regulations prohibit a person or business** from collecting, using, disclosing, or retaining the personal information of a person who is physically located at or within a precise geolocation of a family planning center.
- **Regulations repeal current state provisions that:**
    - Prohibit an abortion from being performed upon an unemancipated minor unless they have first given written consent to the abortion and also has obtained the written consent of one parent or legal guardian.
    - Provide specified judicial procedures when consent of a parent or guardian cannot be

obtained by the pregnant unemancipated minor.

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

SB 189: Health Care Coverage Grievances Independent Medical Review Grievances/Appeals

- Requirement for DMHC-Approved System for Resolution of Grievances
- Time Frame for Grievance Resolution
- Expedited Review for cases involving Imminent and Serious Threat to the Health of the Patient

SB 189 requires California health plans to have a system for resolving Grievances that is approved by the California Department of Managed Health Care. Health plans are required to resolve all grievances within thirty days and to allow for expedited plan review (within 72 hours) for cases involving ".an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function..." Health plans must notify enrollees in writing of their right to file a grievance with the California Department of Managed Health Care, and must also provide information about how to contact the Department. Enrollees are directed to participate in the Plan's grievance process following the time frames outlined above prior to submitting a grievance to the California Department of Managed Health Care for review.

Enrollee Notification

- Time frames and right to contact California Department of Managed Health Care
- Medical Necessity reasons and criteria for denial of authorization
- Specific Information regarding Lack of Coverage for requested authorization.

Health plans are required to provide enrollees and the California Department of Managed Health Care with a written statement on the disposition or pending status of an expedited grievance no later than three days after receipt of the grievance.

Under SB 189, health plan members are to receive responses to grievances with clear and concise explanations of reasons for the Health Plan's responses to the grievance. Further, if the health plan denies payment for services on the basis that the services are not medically necessary, the Plan must provide the clinical reasons related to medical necessity, and a copy of the level of care criteria used. Similarly, if the plan denies payment for services on the basis that they are not covered benefits, the Plan is required to specify the contract provisions that exclude coverage.

Denial of Coverage for Experimental or Investigative Therapy

In appeals/grievances cases involving the denial of coverage for an experimental or investigational therapy, the Enrollee must be informed of his/her right to an immediate external, independent review with an entity under contract with the California Department of Managed HealthCare.

The member must meet the following criteria:

- The member must have a life-threatening or seriously debilitating condition. (*Life-threatening* means either a disease or condition where the likelihood of death is high

unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. *Seriously Debilitating* refers to diseases or conditions that cause major irreversible morbidity.)

- The member's provider must certify that the member has a condition, as defined in paragraph (1), for which:
    i. standard therapies have not been effective in improving the condition of the member, ii. standard therapies would not be medically appropriate for the member, iii. there is no more beneficial standard therapy covered by the health plan than the therapy proposed. Either
        a. the member's network provider ***or***
        b. the member's provider who is not under contract with the health plan but is appropriately licensed and qualified to treat the member's condition, or
        c. the member requests a therapy that, based upon two (2) documents from the medical and scientific evidence, is likely to be more beneficial than standard therapies.

Specific drug, device, procedure or other therapy recommended would be a covered service except for the health plan's determination that the therapy is experimental or investigational.

The health plan's external, independent review must meet the following criteria:

- The health plan must provide written notification to enrollees of their right to request independent review within five business days of the decision to deny coverage for experimental or investigational therapies for conditions that meet the criteria above.
- The Independent Review Organization will be an entity accredited by and under contract with the Department. This entity will arrange for the review of coverage decisions by selecting an independent panel of at least three providers who are experts in the treatment of the enrollee's condition and knowledgeable about the recommended therapy (number of providers on the panel can be less than three under certain prescribed circumstances).
- Within five business days of receipt of the enrollee's request for independent review, Health Net will provide the Independent Review Organization with the documentation described above. The Independent Review Organization must render a decision within 30 days of receipt of the enrollee's request for review, unless a seven-day expedited review is required.
- If a majority of the experts on the Independent Review panel recommend the proposed therapy, the recommendation shall be binding on the Health Plan. If the panel members are evenly divided on coverage, the panel's decision is deemed to be in favor of coverage; if less than a majority of the experts recommend coverage, then the Health Plan is not required to provide coverage for the requested service.

Costs associated with the reviews described above will be paid by the health plan.

Compliance

Health Net established procedures to comply with the regulations outlined above and will continue to process authorization denials and appeals for those denials within the standards of the California Department of Managed Health Care to ensure that health plan members are

notified of their rights according to state regulations. The Health Net appeals system assures that a member entity can submit the grievance to the Department for review when (1) the case involves imminent or serious threat to the health of the patient as defined, or (2) after participating in the Plan's process for 30 days. The Health Net process also assures independent medical review (IMR) for a member who has a life-threatening or seriously debilitating condition when denial of authorization is made on the basis that the service is experimental or investigational.

Health Net will include the IMR Notification and Request Form (located on the DMHC website at www.dmhc.ca.gov) with all letters for denial of authorization for experimental and/or investigational therapy.

Please note that practitioners should carefully document all such cases.

SB 349: Emergency Services and Care

This bill amends California Health and Safety Code to expand the definition of Emergency Services and Care to include:

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 of the bill 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.

Psychiatric Emergency Medical Condition means a psychiatric medical condition whose onset is sudden and manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent lay-person 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, 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.

Compliance

Health Net has established claims and care management policies and procedures to assure compliance with SB 349.

SB 1903 Medical Information Request for Disclosure Partial Summary

Existing law (Section 123110) provides that an adult patient shall be entitled to inspect his or her patient records upon written request to the health care provider. SB1903 would authorize an adult patient to prepare a specified addendum to his or her patient records and require the health care provider to attach that addendum to the patient's records. The bill would also specify that the health care provider shall not be liable for the receipt and inclusion, in and of itself, of the contents of a patient's addendum in the patient's records, as specified.

Compliance

Health Net network practitioners should note this addendum and modify procedures for patient inspection of treatment records accordingly.

Drug Utilization Review Requirements

The health plan and entities delegated to fill prescriptions for outpatient drugs ("applicable entities") must:

- Operate a drug utilization review (DUR) program.[1]
- Submit the following to the Department of Health Care Services (DHCS):
  - Updated policies and procedures that address each of the requirements detailed below.
  - Annual DUR Report.

Claims review requirements

The requirements include the topics listed below.

Concurrent utilization alerts:

- Describe the process for claims review (retrospective) that monitors when the member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. The Plan and applicable entities are provided claims data, including for antipsychotic medications. The Plan and applicable entities are expected to perform, retrospectively, regular care management activities, including a review of concurrent use of opioid and antipsychotic medications, and take action accordingly on issues of concern to them.

  What's excluded from the program:

  The above described claims review requirements do not apply to the Plan members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; Plan members who are receiving opioid agonist medications for treatment of substance use disorder; or other individuals the state elects to treat as exempted from such requirements.

Monitoring of antipsychotic medications used by children

The Plan and applicable entities are required to have a process to monitor and manage appropriate use of all psychiatric drugs to include antipsychotics, mood stabilizers and anti-depressant medications for all children under age 18 and all foster children. Based on the DUR program monitoring findings, the DUR program must have a process to address and improve concerning findings.

Identification of fraud, waste and abuse

Describe the process for identifying and addressing fraud and abuse of controlled substances by members, health care providers who are prescribing drugs to members, and pharmacies dispensing drugs to members. Also describe the actions that will be taken based on issues identified through program-monitoring findings.

[1]The DUR program must comply with Medicaid-related DUR provisions contained in section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R. 6, the SUPPORT Act, P.L. 115-271).

AB 665 Minors: Consent to Mental Health Services

(g) This section shall become inoperative on July 1, 2024, and, as of January 1, 2025, is repealed.

SEC. 3. Section 6924 is added to the Family Code, to read:

6924. (a) As used in this section:

(1) "Mental health treatment or counseling services" means the provision of mental health treatment or counseling on an outpatient basis by any of the following:

(A) A governmental agency.

(B) A person or agency having a contract with a governmental agency to provide the services.

(C) An agency that receives funding from community united funds.

(D) A runaway house or crisis resolution center.

(E) A professional person, as defined in paragraph (2).

(2) "Professional person" means either of the following:

(A) A professional person as defined in Section 124260 of the Health and Safety Code.

(B) The chief administrator of an agency referred to in paragraph (1) or (3).

(3) "Residential shelter services" means any of the following:

(A) The provision of residential and other support services to minors on a temporary or emergency basis in a facility that services only minors by a governmental agency, a person or agency having a contract with a governmental agency to provide these services, an agency that receives funding from community funds, or a licensed community care facility or crisis resolution center.

(B) The provision of other support services on a temporary or emergency basis by any professional person as defined in paragraph (2).

(b) A minor who is 12 years of age 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 person, is mature enough to participate intelligently in the outpatient services or residential shelter services.

(c) A professional person offering residential shelter services, whether as an individual or as a representative of an entity specified in paragraph (3) of subdivision (a), shall make their best efforts to notify the parent or guardian of the provision of services.

(d) The mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor's parent or guardian unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

(e) The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian. The minor's parents or guardian are not liable for payment for any residential shelter services provided pursuant to this section unless the parent or guardian consented to the provision of those services.

(f) 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.

(g) This section shall become operative on July 1, 2024.

DEFINITIONS:

New definitions have been amended as part of the **California Medical Information Act (CMIA),** a state of California regulation, these definitions would be applied across all lines of business.

1. **"Medical information"** means 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.
2. **"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.
3. **"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.
4. **"Sensitive services"** means all health care services related <u>to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence</u>, 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.

AB 1936 Maternal Mental Health Screening Requirements

This bill mandates that providers treating members enrolled in Individual and Family Plans (IFPs) and Employer Group HMO, POS and PPO plans include at least one mental health screening during pregnancy and another within the first six weeks postpartum.

If during the screening the member tests high for depression, please refer them to a behavioral health specialist by calling the number on the back of their medical ID card.