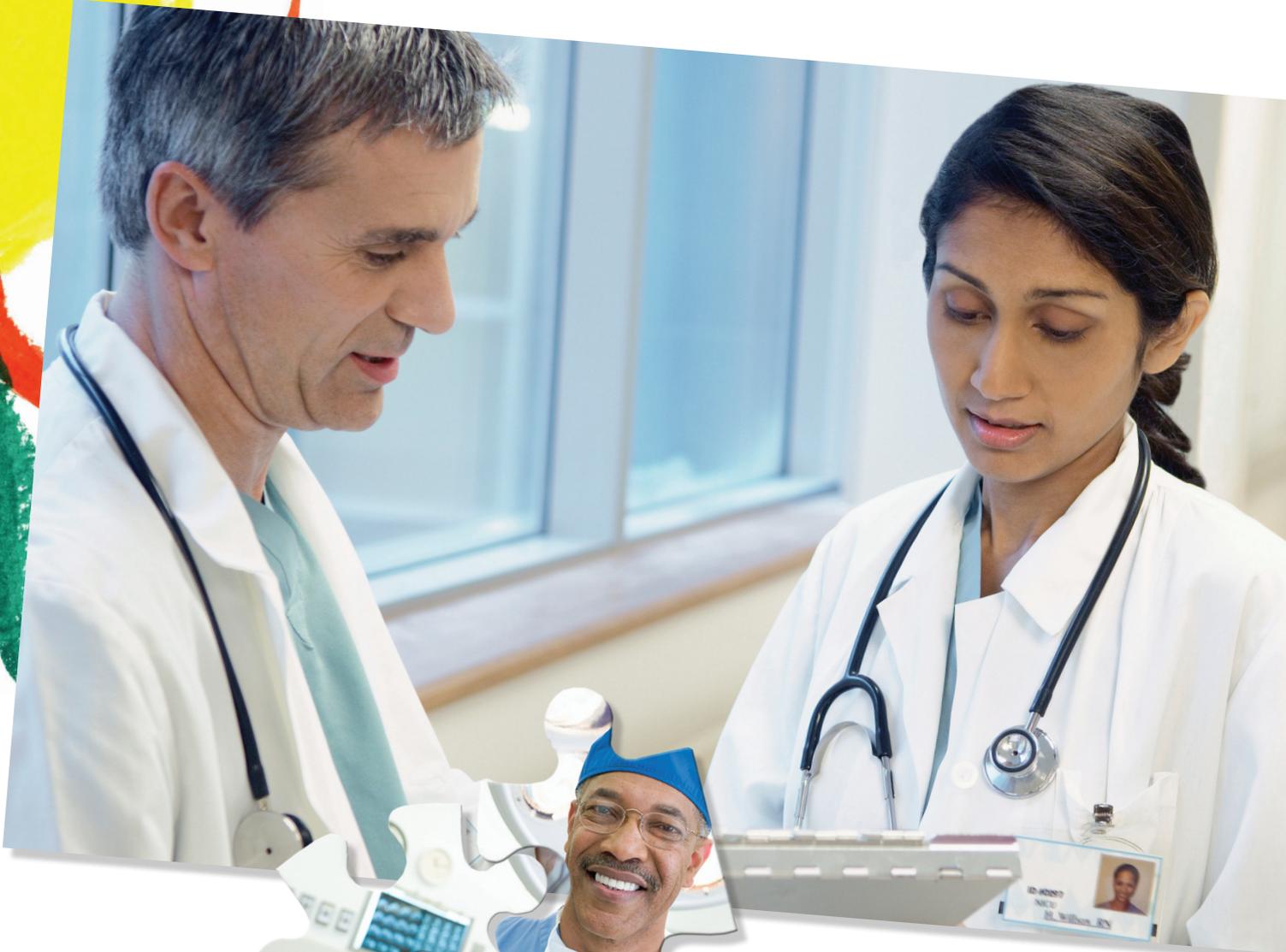


# Provider Reference Guide

Arizona



**Lisa Pasillas-Le,  
Health Net**  
*We help you work efficiently  
with Health Net.*



**Health Net  
Access™**



# INTRODUCTION

Health Net Access, Inc., a subsidiary of Health Net, Inc., is a contractor for the Arizona Health Care Cost Containment System (AHCCCS) offering Health Net Access, Health Net's Medicaid managed care program, in Maricopa County. Medical care is provided to Health Net Access members through private physicians practicing individually or together in multispecialty medical groups.

Effective October 1, 2015, behavioral health care services for General Mental Health and Substance Abuse (GMH/SA) for dual-eligible Medicare and Medicaid members who have chosen Health Net Access as their Medicaid plan will be managed by Health Net Access. Dual-eligible members are members who are eligible and enrolled for coverage through Medicare and Medicaid. Regional Behavioral Health Authorities (RBHAs), and/or the Tribal/Regional Behavioral Health Authorities (T/RBHAs) will continue to administer the benefits for children, individuals with serious mental illness (SMI), and those who are not dually eligible for Medicare and Medicaid.

The Health Net Access Provider Reference Guide is a summary of the Health Net Access Provider Operations Manual, which is available in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com). Providers are encouraged to use the electronic version of the Health Net Access Provider Operations Manual when possible for the most current and comprehensive information. Updated information in the electronic version of the manual supersedes information contained in this print guide.

## Using the guide

The guide contains information about the essential administrative components of the Health Net Access plan and working with GMH/SA members, which includes:

- claims billing and submission, provider disputes, third-party liability, coordination of benefits
- Health Net Access policies and procedures
- prior authorization and referral information
- health care access and coordination
- quick reference contact information for Health Net Access and public health agencies

For more detailed information about these topics, consult the comprehensive Health Net Access Provider Operations Manual.

## Disclaimer

The contents of this guide are supplemental to the *Provider Participation Agreement (PPA)\**. When the contents of this guide conflict with the *PPA*, the *PPA* takes precedence. Updates to the information in this guide are made through provider updates or signed letters distributed by fax, the United States Postal Service or other carrier. Provider updates and signed letters are to be considered amendments to this guide.

This guide is not intended to provide legal advice on any matter and may not be relied on as a substitute for obtaining advice from a legal professional.

\*Behavioral health providers are contracting with, or had their contracts amended by, MHN, a Health Net affiliate. The MHN *PPA* also takes precedence over the Health Net Access Provider Operations Manual if the contents of the manual and *PPA* conflict.

This page intentionally left blank

---

# TABLE OF CONTENTS

General Billing Information .....	1.1
Filing a claim .....	1.1
Timely filing .....	1.1
Clean claim submission guidelines .....	1.2
Electronic claims .....	1.2
Corrected claims submission .....	1.2
Reports .....	1.3
EDI questions .....	1.3
Paper claims submissions .....	1.3
Claims questions .....	1.4
Disputing a claim payment or denial .....	1.4
Provider dispute time frame .....	1.4
Submitting provider disputes .....	1.4
Provider disputes for authorization denials .....	1.5
Acknowledgement of provider disputes .....	1.5
Resolution time frame .....	1.5
Past due payments .....	1.5
Dispute resolution costs .....	1.5
Provider state fair hearing .....	1.5
Disputes and provider state fair hearing submission .....	1.6
Specific billing requirements .....	1.6
Anesthesia .....	1.6
Assistant surgeon .....	1.6
Behavioral health .....	1.6
Billing by report .....	1.7
Multiple surgeons .....	1.7
Newborn billing .....	1.7
Third-party liability .....	1.7
Provider responsibilities .....	1.7
Coordination of benefits .....	1.8
Providing COB information .....	1.8
COB payment calculations .....	1.9
Overpayments .....	1.9
Additional information .....	1.10
Policies and Procedures .....	2.1
Appointment accessibility standards .....	2.1
Office hours and equipment .....	2.3

## Table of Contents

---

After-hours guidelines .....	2.3
Advance directives.....	2.3
Balance billing.....	2.4
Choosing a covering and collaborating physician.....	2.4
Health care fraud, waste and abuse .....	2.5
Reporting fraud, waste and abuse.....	2.5
Federal False Claims Act .....	2.5
Hospitalists.....	2.6
Cultural competency and language assistance services.....	2.6
Medical record requests .....	2.7
Member eligibility verification .....	2.8
Missed appointments/no shows.....	2.8
PCP closure.....	2.8
PCP termination .....	2.8
Provider responsibilities.....	2.9
Provider right to advocate on behalf of the member.....	2.10
Nondiscrimination.....	2.10
Prior Authorization Procedures .....	3.1
Referrals .....	3.1
Prior authorization.....	3.1
Requests .....	3.1
Review and approval process.....	3.2
Responses.....	3.2
Services requiring prior authorization.....	3.3
Emergencies .....	3.3
Behavioral health services .....	3.3
Prescription medication prior authorization requests.....	3.4
Notification of admissions .....	3.4
Required information.....	3.4
Notification process.....	3.5
Questions.....	3.5
Health Care Access and Coordination.....	4.1
Early and Periodic Screening, Diagnosis, and Treatment .....	4.1
Requirements for EPSDT providers .....	4.1
Care coordination .....	4.1
Screenings .....	4.2
Documentation requirements.....	4.2
Vaccines for Children program .....	4.2

Arizona Early Intervention Program ..... 4.3  
    PCP-initiated services ..... 4.3  
    AzEIP-initiated services ..... 4.4  
Parent’s Evaluation of Developmental Screening tool ..... 4.5  
Maternity care provider requirements ..... 4.5  
Behavioral health coordination ..... 4.6  
Behavioral health coverage overview ..... 4.6  
Quick Reference ..... 5.1

This page intentionally left blank

---

# GENERAL BILLING INFORMATION

## Filing a claim

Providers are encouraged to file claims electronically whenever possible. When submitting claims, it is important to accurately provide all required information. Claims submitted with missing data may result in a delay in processing or denial of the claim. All facility claims are required to be submitted electronically via an 837 Institutional transaction to payer identification (ID) 38309 or via paper on a UB-04 claim form. Professional fees must be submitted electronically on an 837 Professional transaction to payer ID 38309 or on an original (red) CMS 1500 claim form. Copies of claim forms are not accepted. Maximum allowable amounts must be billed (not scheduled allowables). Participating providers receive a Remittance Advice (RA) each time a claim is processed.

### *Timely filing*

When Health Net Access is the primary payer, claims must be submitted no later than six months from the service date, except for retro-eligibility claims\*. For inpatient hospital claims, the date of service is the patient's discharge date. Claims submitted more than six months after the date of service are denied. When Health Net Access is the secondary payer, claims must be submitted within six months from the date of service even if payment from Medicare or other insurance has not been received. A copy of the primary carrier's *Explanation of Benefits (EOB)* must be attached to the claim form.

If payment is denied based on a provider's failure to comply with timely filing requirements, the claim is treated as nonreimbursable and cannot be billed to the member.

Acceptable proof of timely filing includes:

- computer-generated billing ledger showing Health Net Access was billed within Health Net Access' timely filing limits
- *EOB* from another insurance carrier dated within Health Net Access' timely filing limits
- denial letter from another insurance carrier printed on its letterhead and dated within Health Net Access' timely filing limits
- electronic data interchange (EDI) rejection report from clearinghouse that indicated claim was forwarded and accepted by Health Net Access (showing date received versus date of service), which reflects the claim was submitted within Health Net Access' timely filing limits. Claims that were rejected must be corrected and resubmitted in a timely manner

Unacceptable proof of timely filing includes:

- screen-print of claim invoice
- copy of original claim
- denial letter from another insurance carrier without a date and not on letterhead
- record of billing stored in an Excel spreadsheet

\*A retro-eligibility claim is a claim where no eligibility was entered in the system for the date(s) of service, but eligibility was posted at a later date retroactively to cover the date(s) of service. Retro-eligibility claims must be submitted no later than six months from the date of the eligibility posting. They must attain clean claim status no later than 12 months from the date of eligibility posting. All claims must be filed within one year of the date of service under the terms of Health Net coverage plans.

## Clean claim submission guidelines

A “clean claim” is a claim that can be processed without obtaining additional information from the provider of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

A claim is considered “clean” when the following conditions are met:

- all required information has been received by Health Net Access
- the claim meets all Arizona Health Care Cost Containment System (AHCCCS) submission requirements
- the claim is legible enough to permit electronic image scanning
- any errors in the data provided have been corrected
- all medical documentation required for medical review has been provided

Reasons for claim denial include, but are not limited to, the following:

- duplicate submission
- member is not eligible for date of service
- incomplete data
- noncovered services
- provider of service is not registered with AHCCCS on the date of service

## Electronic claims

Health Net contracts with Capario (now part of Emdeon), Emdeon and MD On-Line (now part of ABILITY® network) to provide claims clearinghouse services for Health Net Access electronic claim submission. Additional clearinghouses/vendors can submit using these channels. Providers should contact their vendors directly for instructions on submitting claims to Health Net Access.

The benefits of electronic claim submission include:

- reduction and elimination of costs associated with printing and mailing paper claims
- improvement of data integrity through the use of clearinghouse edits
- faster receipt of claims by Health Net Access, resulting in reduced processing time and quicker payment
- confirmation of receipt of claims by the clearinghouse
- availability of reports when electronic claims are rejected
- the ability to track electronic claims, resulting in greater accountability

## Corrected claims submission

Providers must correct and resubmit claims to Health Net Access within the 12-month clean claim time frame. When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. The original claim reference number from the remittance advice (RA) must be included on the claim in order for Health Net Access to identify the claim resubmitted. If the claim reference number is missing, the claim may be entered as a new claim and denied for being submitted beyond the initial submission time frame.

Corrected claims must be appropriately marked as such and submitted to the appropriate claims mailing address.

Clearinghouse Information			
Clearinghouse	Telephone number	Website	Health Net payer ID number*
<b>CAPARIO</b>	1-888-894-7888	www.capario.com	38309
<b>EMDEON</b>	1-877-469-3263	www.emdeon.com	38309
As a result of Health Net's agreement with MD On-Line, all payer claims can be submitted electronically via the provider website at provider.healthnet.com.			
<b>MD ON-LINE</b>	1-888-499-5465	www.healthnet.com www.mdon-line.com	38309

\*The payer ID number must be included with every claim. Providers may register for electronic claims submission at provider.healthnet.com.

Participating providers are encouraged to review all electronic claim submission acknowledgement reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse (Capario, Emdeon or MD On-Line).

## Reports

For successful EDI claim submission, providers and facilities must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting, including:

- acceptance/rejection reports from EDI vendor
- acceptance/rejection reports from EDI clearinghouse
- acceptance/rejection reports from Health Net Access

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

Providers may also check the status of paper and electronic claims using the claims status transaction (276/277) via EDI through their clearinghouse or on the provider website at provider.healthnet.com.

## EDI questions

For questions regarding electronic claim submission, contact the dedicated EDI line by telephone at 1-866-334-4638 or by email at edi\_support@healthnet.com.

## Paper claims submissions

Health Net Access providers must send initial paper claims and claims resubmitted with the additional information Health Net Access has requested to:

Health Net Access, Inc.  
PO Box 14095  
Lexington, KY 40512

## Claims questions

For automated claim status information, contact the Provider Services Center at 1-888-788-4408.

## Disputing a claim payment or denial

A provider dispute is a written notice from the provider to Health Net Access that:

- challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested
- challenges a request for reimbursement for an overpayment of a claim
- seeks resolution of a billing determination or other contractual dispute

Providers should exhaust all authorized processing procedures and follow the guidelines below before filing a claim dispute with Health Net Access:

- If the provider has not received a Health Net Access RA identifying the status of the claim, he or she should call the Provider Services Center to inquire whether the claim has been received, processed and what the status is.
- Providers should allow ample time following claim submission before inquiring about a claim. However, providers should inquire well before six months from the date of service because of the time frame for initial claim submission and for filing a claim dispute.
- If a claim is pending in Health Net Access' claim system, a claim dispute is not investigated until the claim is paid or denied. A delay in processing a claim may be a cause to entertain a claim dispute on a pended claim provided all claim dispute deadlines are met.
- If the provider has exhausted all authorized processing procedures, the provider has a right to request a provider state fair hearing through AHCCCS.

### *Provider dispute time frame*

Disputes are accepted if they are submitted no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later and as described above.

If the provider's contractual agreement provides for a dispute-filing deadline that is greater or less than 365 calendar days, this time frame continues to apply unless and until the contract is amended.

### *Submitting provider disputes*

Providers should submit provider disputes on a Provider Claim Dispute form. If the dispute is for multiple and substantially similar claims, a Provider Claim Dispute spreadsheet should be submitted along with the form. Providers may download an electronic copy of the Provider Claim Dispute form by visiting the Forms section in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

The provider's dispute must include the provider's name, ID number, contact information including telephone number, and the number assigned to the original claim. Additional information required includes:

- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.

- If the dispute is not about a claim, a clear explanation of the issue and the basis of the provider's position.

If the provider dispute does not include the required submission elements as outlined above, the dispute is returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the missing information.

Health Net Access does not request that providers resubmit claim information or supporting documentation that was previously submitted to Health Net Access as part of the claims adjudication process unless Health Net Access returned the information to the provider.

Health Net Access does not discriminate or retaliate against a provider due to a provider's use of the provider dispute process.

Health Net Access accepts the Provider Claim Dispute form and other methods of submission, such as a letter.

### *Provider disputes for authorization denials*

A provider dispute that is submitted on behalf of a member for services not billed or rendered and for which there is an authorization denial should not be submitted through the Provider Appeals and Grievances Department, but rather through the member appeals process, granted the member has authorized the provider to appeal on the member's behalf. If the Provider Appeals and Grievances Department receives this type of appeal, it will be forwarded for processing.

### *Acknowledgement of provider disputes*

Health Net Access acknowledges receipt of each provider dispute, regardless of whether the dispute is complete, within five business days of receipt.

### *Resolution time frame*

Health Net Access resolves each provider dispute within 30 business days following receipt of the dispute, and provides a written determination.

### *Past due payments*

If the provider dispute involves a claim and it is determined to be in favor of the provider, Health Net Access pays any outstanding money due, including any required interest or penalties, within 15 business days of the date of the decision. When applicable, accrual of the interest and penalties commences on the day following the date by which the claim should have been processed.

### *Dispute resolution costs*

A provider dispute is processed without charge to the provider; however, Health Net Access has no obligation to reimburse any costs that the provider has incurred during the dispute process.

### *Provider state fair hearing*

If a provider disagrees with the resolution of a dispute, he or she may file a request to Health Net Access for a state fair hearing through the AHCCCS Office of Administrative Legal Services (OALS). The request must be received in writing within 30 days of the dispute decision, and

Health Net Access submits all supporting documentation received to the OALS no later than five business days from the date Health Net Access receives the provider's written request.

When a provider files a written request for a hearing, Health Net Access reviews the matter to determine why the request for hearing was filed and resolves the matter when appropriate. If Health Net Access decides to reverse its decision, in full or in part, through the dispute process, Health Net Access reprocesses and pays the claim(s) in a manner consistent with the decision along with any applicable interest within 15 business days of the date of the decision.

### *Disputes and provider state fair hearing submission*

Claim disputes must be submitted to:

Health Net Access, Inc.  
Attention: Provider Disputes  
1230 West Washington Street, Suite 401  
Tempe, AZ 85281

Provider state fair hearings must be submitted to:

Health Net Access, Inc.  
Attention: Provider State Fair Hearings  
1230 West Washington Street, Suite 401  
Tempe, AZ 85281

## Specific billing requirements

### *Anesthesia*

Anesthesia services (except epidurals) require the continuous physical presence of the anesthesiologist or certified registered nurse anesthetist (CRNA). Anesthesiologists and CRNAs must enter the approved American Society of Anesthesiologists (ASA) code in field 24D and the total number of minutes in field 24G of the CMS 1500 claim form.

### *Assistant surgeon*

Include the name of the surgeon in box 17 of the CMS-1500 form. Use modifier 80 after the applicable CPT-4 code. When billing multiple surgical procedures, secondary procedures should have modifier 80 and modifier 51.

### *Behavioral health*

Pseudo identification numbers are only applicable to behavioral health providers under contract with Health Net Access.

In some instances, such as crisis episodes, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted, allowing Health Net Access and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- crisis intervention services (mobile),

- case management, and
- transportation.

Pseudo identification numbers must only be used as a last option when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. For a list of available pseudo identification numbers, contact Health Net Access at 1-888-788-4408.

### ***Billing by report***

Include the operative report or chart notes for "by report" procedures, including high-level examinations or consultations.

### ***Multiple surgeons***

Include the appropriate modifiers to ensure proper payment of claims. Use modifier 80 for assistant surgeon, modifier 62 for two surgeons and modifier 66 for surgical team.

### ***Newborn billing***

Providers must notify the Health Net Access Newborn Data Collection Unit at 1-800-977-7518 of all newborn admissions within 24 hours or no later than three days after delivery. Identify the admitting pediatrician when calling in the notification. The time frame ensures proper enrollment of the newborn with AHCCCS and in a Health Net Access plan.

Newborns whose mothers are Health Net Access members are eligible for Health Net Access from the time of delivery. Newborns receive separate Health Net Access ID numbers, and services for a newborn must be billed separately using the newborn's ID number.

## **Third-party liability**

If a Health Net Access member is injured through the act or omission of another person, the participating provider must provide benefits in accordance with the *Member Handbook*. If the member is entitled to recovery, Health Net Access is entitled to recover and retain the value of the services provided from any amounts received by the member from sources, including, but not limited to, the following:

- uninsured/underinsured motorist insurance
- workers' compensation
- estate recovery
- first- and third-party liability insurance
- tortfeasors, including casualty
- restitution recovery
- special treatment trust recovery

### ***Provider responsibilities***

The participating provider must question the member for possible third-party liability (TPL) and workers' compensation in injury cases. Often, the member does not mention that this liability exists, having received complete care without charge from the participating provider and may not feel that it is necessary. The participating provider must check for this liability where treatment is being provided. The participating provider must develop procedures to identify these cases.

After TPL has been established, the participating provider must provide Health Net Access with the information using the Request for Prior Authorization form or other correspondence. The participating provider must continue to provide benefits in accordance with the *Member Handbook*.

### **Workers' compensation**

If the provider identifies that the member's injuries are due to a workers' compensation injury, the provider must bill the employer's industrial insurance carrier first when responsibility has been established. Health Net Access pays for claims denied by the employer's industrial insurance carrier if all of the following occurs:

- A copy of the denial is sent with the claim to Health Net Access.
- All Health Net Access authorization requirements have been met.
- The service provided is a covered benefit under the member's benefit plan.

### **Pending cases**

In cases pending settlement or possible legal action, providers should bill Health Net Access as usual, giving all details regarding the injury or illness. Health Net Access pays usual benefits and may then file a lien for reimbursement from the responsible party when permitted under law.

## Coordination of benefits

Coordination of benefits (COB) is required before submitting claims for members who are covered by one or more health insurers other than Health Net Access. Health Net Access is always the payer of last resort, including Medicare and TRICARE.

Participating providers are required to administer COB. The participating provider should ask the member for possible coverage through another health plan and enter the other health insurance information on the claim.

### ***Providing COB information***

In order for Health Net Access to document member records and process claims appropriately, include the following information on all COB claims:

- name of the other carrier
- subscriber ID number with the other carrier

If a Health Net Access member has other group health coverage, follow these steps:

- File the claim with the primary carrier.
- After the primary carrier has paid, attach a copy of the *Explanation of Payment (EOP)* or *EOB* to a copy of the claim and submit both to Health Net Access within the timely filing limit of six months from the date of service. COB claims can also be submitted electronically with the details from the other payer ERA appropriately submitted in the 837 transaction COB loops.
- If the primary carrier has not made payment or issued a denial, submit the claim to Health Net Access prior to the timely filing limit of six months from the date of service. Health Net Access must receive a clean claim within 12 months of the date of service.

If denied on the basis of timeliness, the claims are treated as non-reimbursable and the member cannot be billed.

### *COB payment calculations*

As the secondary carrier, Health Net Access coordinates benefits and pays balances, up to the member's liability, for covered services. However, the dollar value of the balance payment cannot exceed the dollar value of the amount that would have been paid had Health Net Access been the primary carrier.

In most cases, members who have coverage through two carriers are not responsible for cost-shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member. Copayments are waived when a member has other insurance as primary coverage.

## Overpayments

Health Net Access makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's RA. An automatic system offset, where applicable, might occur in accordance with the reprocessing of the claim for the overpayment, or on immediate subsequent check runs.

In the event that a provider independently identifies an overpayment from Health Net Access (such as a credit balance), the following steps are required by the provider:

- Send a check made payable to the appropriate entity (Health Net Access).
- Include a copy of the RA that accompanied the overpayment to expedite Health Net Access' adjustment of the provider's account. It takes longer for Health Net Access to process the overpayment refund without the RA. If the RA is not available, the following information must be provided:
  - Health Net Access member name
  - date of service
  - payment amount
  - Health Net Access member ID number
  - vendor name
  - provider tax ID number
  - provider number
  - vendor number
  - reason for the overpayment refund
- Send the overpayment refund and applicable details to:
  - Health Net Access Overpayment Recovery Department
  - Health Net of Arizona Claims Refunds
  - File 749801
  - Los Angeles, CA 90074-9801

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net Access, the provider should follow the overpayment refund instructions provided by the vendor.

If a provider believes he or she has received a Health Net Access check in error and has not cashed the check, he or she should return the check to the Health Net Access Overpayment Recovery Department

at the above address with the applicable RA and a cover letter indicating why the check is being returned.

### Additional information

Contact the Provider Services Center at 1-888-788-4408 with questions regarding third-party recovery, coordination of benefits or overpayments.

Complete billing information is available through Health Net Access Provider Network Management or in the Health Net Access Provider Operations Manual in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

## POLICIES AND PROCEDURES

All participating providers agree to abide by Health Net Access' policies and procedures. Failure to comply with policies and procedures may result in claim delays, denials or sanctions, up to and including termination of the *Provider Participation Agreement (PPA)*. This section highlights some of the frequently asked questions about policies and procedures. For questions about these or other policies, contact a Health Net Access provider network representative.

Complete policy and procedure information is available on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

### Appointment accessibility standards

The following appointment access guidelines ensure timely health services are available to Health Net Access members.

Appointment Accessibility Standards	
Type of Care	Accessibility Standard*
<b>PRIMARY CARE</b>	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 2 days of request
Routine	Within 21 days of request
<b>SPECIALTY REFERRAL</b>	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral
<b>MATERNITY</b>	
1 <sup>st</sup> trimester	Within 14 days of request
2 <sup>nd</sup> trimester	Within 7 days of request
3 <sup>rd</sup> trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
<b>DENTAL</b>	
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

The in-office wait time is less than 45 minutes, except when the provider is unavailable due to an emergency.

The following are behavioral health appointment access guidelines:

Appointment Type	Description	Standard*
Immediate	Behavioral health services provided within a time frame indicated by behavioral health condition, but no later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical	Within 2 hours – may include telephonic or face-to-face interventions
Urgent	Behavioral health services provided within a time frame indicated by behavioral health condition but no later than 24 hours from identification of need	Within 24 hours
Routine – initial assessment	Appointment for initial assessment with a BHP within 7 days of referral or request for behavioral health services	Within 7 days of referral
Routine – first behavioral health service	Includes any medically necessary covered behavioral health service including medication management and/or additional services	Within 7 days of assessment
Appointments for psychotropic medication		<p>The member’s need for medication is assessed immediately and, if clinically indicated, the member is scheduled for an appointment within a time frame that ensures:</p> <ol style="list-style-type: none"> <li>1. The member does not run out of any needed psychotropic medications; or</li> <li>2. The member is evaluated for the need to start medications to ensure that the member does not experience a decline in his or her behavioral health condition.</li> </ol>
Referrals or requests for psychotropic medications	Screening, consultation, assessment, medication management, medications, and/or lab testing services, as appropriate	Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHP within a time frame indicated by clinical need, but no later than 30 days from the referral/initial request for services.
Non-emergency transportation		<ul style="list-style-type: none"> <li>• Member must not arrive sooner than one hour before his or her scheduled appointment; and</li> <li>• Member must not have to wait for more than one hour</li> </ul>

		after the conclusion of his or her appointment for transportation home or to another pre-arranged destination.
In-office wait times	The member must not wait more than 45 minutes in the office to see his or her provider; except when the provider is unavailable due to an emergency.	Within 45 minutes

\*Appointment accessibility standards are subject to change as regulatory requirements are updated.

## Office hours and equipment

Participating providers are required to maintain offices, equipment and staff to provide all contracting services within the scope of their licensure. Offices must be open during normal business hours and be available 24 hours a day, seven days a week for emergencies. After-hours availability may be through a coverage arrangement.

## After-hours guidelines

As required by applicable statutes, under Code of Federal Regulations (CFR) 42 Section 422.112(a)(7) and 42 Section 438.206(c)(1)(iii) and according to the signed *PPA*, Health Net Access participating providers must ensure that, when medically necessary, services are available 24 hours a day, seven days a week; and PCPs are required to have appropriate backup for absences. Medical groups and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instructions about after-hours access to medical care.

After office hours (outside of normal business hours or when the offices are closed), PCPs or on-call physicians are required to return calls and pages within four hours. If an on-call physician cannot be reached, the after-hours answering service or machine must direct the member to a medical facility where emergency or urgent care treatment can be provided. According to Arizona Administrative Code (AAC) Section R-20-6-1914(4), in-area urgent care services from a participating provider must be available seven days a week.

The PCP or the on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room as medically necessary.

## Advance directives

Participating providers are required to comply with federal and state law regarding advance directives for adult members. Providers are, therefore, expected to discuss advance directives options with all adult members ages 18 and older, including whether or not the member has instituted an advance directive. Documentation of a discussion on advance directives is included as a required element in the Health Net Access Medical Record Standards. Documentation of the advance directive discussion and where this document is housed are included as elements in the medical record review that is performed by the Quality Management Department.

Advance directive information must be documented in a prominent place in the member's chart, including the date of discussion of an advance directive and a copy of the member's advance directive. Members have the right to make and control their own health care decisions.

## Balance billing

Balance billing is the practice of a participating provider billing a member for the difference between the contracting amount and billed charges for covered services. When participating providers contract with Health Net Access, they agree to accept Health Net Access' contracting rate as payment in full. Billing members for any covered services is a breach of contract, as well as a violation of the PPA and state and federal (ARS 20-1072) statutes. In some instances, balance billing of members can result in civil penalties as stated in ARS 36-2903.01(L). Participating providers may only seek reimbursement from Health Net Access members for copayments, coinsurance or deductibles.

Guidelines for billing Health Net Access members are listed as follows:

- Providers can bill a Health Net Access member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services. Place the document in the member's medical record.
- Health Net Access members must not be billed or reported to a collection agency for any covered service provided.
- Providers may not charge members for services that are denied or reduced due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization or lack of clean claim status.
- Providers must not collect copayments, coinsurance or deductibles from members with other insurance whether it is Medicare or a commercial carrier. Providers must bill Health Net Access for these amounts, and Health Net Access coordinates benefits.

## Choosing a covering and collaborating physician

Health Net Access providers who use other physicians to cover their practice while on vacation or leave must make their best efforts to find a Arizona Health Care Cost Containment System (AHCCCS)-registered, Health Net Access participating physician within the same specialty. If a Health Net Access participating physician is unable to cover the practice, the following must occur:

- The nonparticipating physician must agree in writing to abide by the terms of Health Net Access' contract and all Health Net Access policies and procedures.
- Health Net Access must give prior approval for the use of a nonparticipating physician.

Providers may request approval to use a nonparticipating, covering physician by contacting the Provider Network Management Department.

When choosing a physician to collaborate on a case, providers must utilize AHCCCS-registered participating providers. Payment for surgical assistants, as well as second opinions, may be deemed the requesting physician's responsibility if the provider requested is not an AHCCCS-registered participating provider. Payment by Health Net Access for these services is dependent on medical appropriateness, contract status, member eligibility, and the member's benefit plan.

## Health care fraud, waste and abuse

Health care fraud contributes to the rising cost of health insurance, reduces the amount of funds available to pay providers, and increases premiums to employers and members. We investigate allegations of fraud, waste and abuse (FWA) and reports of noncompliance at every level. Below are examples of health care fraud and unethical or noncompliant activities:

- Consumer health care fraud: Filing claims for services or medications not received, forging or altering bills or receipts, or using someone else's coverage or insurance card.
- Provider health care fraud: Billing for services not actually performed, falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary, or upcoding – billing for a more costly service than the one actually performed.
- Unethical or non-compliant activities: Falsifying or tampering with company documents or records, accepting gifts or favors that may influence a business decision, violating Health Net's Code of Business Conduct and Ethics, or accessing personal information or protected health information (PHI) without authorization.

### *Reporting fraud, waste and abuse*

State law requires that Health Net Access report instances of suspected insurance fraud. Such instances may include, but are not limited to:

- material misstatements of facts or omissions on insurance applications
- false claims
- false, forged or altered prescriptions
- misuse of Health Net Access ID cards

We have adopted processes to receive, record and respond to compliance questions, reports of potential or actual noncompliance, and FWA from contractors, agents, directors, enrollees, and providers. Health Net Access maintains confidentiality to the extent possible, allows callers to remain anonymous if desired and ensures nonretaliation against those who report suspected misconduct.

To report suspected fraud, waste or abuse involving a Health Net Access member, contact us via mail or telephone at:

Health Net, Inc. Special Investigations Unit  
PO Box 2048  
Rancho Cordova, CA 95741-2048  
Health Net's Fraud Hotline: 1-800-977-3565

Health Net Access also asks providers to assist us and, if necessary, AHCCCS in investigating instances of suspected fraud.

### *Federal False Claims Act*

The federal False Claims Act (FCA) provides that the following acts are unlawful:

- Knowingly presenting, or causing to be presented, a false or fraudulent claim to an officer or employee of the United States (U.S.) government.
- Knowingly making or using, or causing the making or use, of a false record or statement to get a false or fraudulent claim paid.
- Conspiring to defraud the government by getting a false or fraudulent claim paid.

- Knowingly making or using, or causing the making or use, of a false record or statement to conceal, avoid or decrease an obligation to the government.

### **Penalties under the Federal False Claims Act**

Any person or corporation who violates the federal FCA is subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted in violation of the federal FCA. In addition to the civil penalty, persons are liable to the government for three times the amount of damages the government sustains.

## Hospitalists

Health Net Access contracts with several hospitalist service providers. Participating hospitalists must be used whenever hospitalist services are required, or the Health Net Access member's primary care physician (PCP) or specialist may admit the member, as necessary. For assistance locating a participating hospitalist, contact the admitting facility directly or the Provider Services Center during normal business hours at 1-888-788-4408.

Hospitalists are required to provide the following member discharge information to the member's PCP within 72 hours of the member's discharge from the hospital:

- admission and discharge dates
- presenting problem
- discharge diagnoses
- discharge medications
- follow-up instructions

Refer to the Discharge Summary Form located in the Forms section of the Provider Library at [provider.healthnet.com](http://provider.healthnet.com), or incorporate these standards into the form currently used.

## Cultural competency and language assistance services

Health Net Access fully complies with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate services in health care (CLAS standards) and state requirements, which includes ensuring that all members, including those with limited English proficiency (LEP) have meaningful access to health care services.

Further, members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay, or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- those with limited English proficiency (LEP) or reading skills
- those with diverse cultural and ethnic backgrounds
- the homeless
- individuals with physical and mental disabilities

Health Net Access provides no-cost language assistance, interpretation and translation services to members to support member's ability to direct their care. Language assistance services include:

- interpreter services for clinical appointments

- sign language services for clinical appointments
- a statement in all notices Health Net Access sends to members that indicates how to access language services in any applicable non-English language

Providers who need a sign language interpreter present at their site may schedule an appointment three to five business days prior to the member's appointment. Providers may request an onsite interpreter (excluding sign language interpreters) three days prior to the appointment. If the provider cannot schedule the interpreter a minimum of three days prior to the appointment, then a telephone interpreter is made available. Health Net Access arranges and pays for interpreter service, and no prior authorization or billing is needed. The provider, member or caregiver can arrange for an interpreter by calling the Health Net Access Provider Services Center at 1-888-788-4408 or the number on the member identification (ID) card.

Health Net Access participating providers are required to support and comply with the following services:

- Interpreter services – Use qualified interpreters or multilingual provider staff, who have been assessed for their language skills for limited-English proficient (LEP) members.
- Medical record documentation – Document the member's language preference (including English) and the refusal or use of interpreter services in the member's medical record. The medical record documentation must be written in English.
- Health Net Access strongly discourages the use of family, friends or minors as interpreters. If, after being informed of the availability of no-cost interpreter services, the member prefers to use family, friends or minors as interpreters, the provider must document this in the member's medical record.

## Medical record requests

In accordance with Arizona state law, members are entitled to a copy of their medical records annually at no cost from any health care professional who has treated them. If a member's appeal or request requires Health Net Access to review medical records, the provider must release the records to Health Net Access. Certain restrictions may apply if the records contain information regarding the member's behavioral health status or genetic testing results.

Providers must ensure availability and accessibility of a member's medical records to the member in a timely manner in accordance with industry standards.

Release of medical information guidelines must address:

- requests for protected health information (PHI) via telephone
- demands made by subpoena *duces tecum*
- timely transfer of medical records to ensure continuity of care when a Health Net Access member chooses a new PCP
- availability and accessibility of member medical records to Health Net Access 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 422.118(d)
- requirements for medical record information between providers of care requesting information from another treating provider as necessary to provide care

- use of health information exchanges and other information sharing mechanisms, including member portals within the provider's electronic medical record

### Member eligibility verification

Providers are responsible for verifying eligibility for all medical services provided. Providers may verify member eligibility through the AHCCCS interactive voice response (IVR) system at (602) 417-7200 or on the AHCCCS website at [azweb.statemedicaid.us](http://azweb.statemedicaid.us).

Providers are responsible for verifying eligibility for Medicare and Medicaid GMH/SA dual-eligible members as follows for all services provided.

- Medicare eligibility: Check the member's Medicare ID card, which indicates coverage through Original Medicare, Health Net of Arizona Medicare Advantage, or another Medicare Advantage plan. Call the 800 number located on the back of the card to verify eligibility.
- Health Net Access eligibility: Check the member's Medicaid ID card, which indicates coverage for behavioral health services through the Regional Behavioral Health Authority (RBHA), the Tribal/Regional Behavioral Health Authority (T/RBHA) or HN Access. Call the 800 number on the card for behavioral health to verify eligibility.
- AHCCCS eligibility can also be verified through the AHCCCS interactive voice response (IVR) system at (602) 417-7200 or on the AHCCCS website at [azweb.statemedicaid.us](http://azweb.statemedicaid.us).

### Missed appointments/no shows

Providers are expected to follow up with members who miss or cancel appointments and to notify Health Net Access when a member has missed or cancelled three or more visits. Providers may utilize the Health Net Access Missed Appointment/No Show Log located in the Forms section of the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

Providers are encouraged to use the recall system in order to reduce the number of missed or cancelled appointments.

### PCP closure

PCPs may close their practices to new Health Net Access members while remaining open to members of other insured or managed health care plans, provided that the PCP meets the threshold of 300 Health Net Access members before closing the panel.

If the PCP's patient was a member of another health care plan and joins Health Net Access, in order to maintain continuity of care, the PCP must accept the member as a patient even if his or her practice is closed to new Health Net Access members.

A PCP may close his or her practice to all new patients from all insurance or health plans at any time.

### PCP termination

Participating providers terminating their contract with Health Net Access must provide advance notice as required in the *PPA* in order to ensure continuity of care to members undergoing an active course of treatment.

---

## Provider responsibilities

Participating providers are responsible for:

- providing health care services to Health Net Access members within the scope of the provider's practice and qualifications
- providing care that is consistent with generally accepted standards of practice prevailing in the provider's community and the health care profession
- accepting Health Net Access members as patients on the same basis that the provider accepts other patients (nondiscrimination)
- when consistent with provision of appropriate quality of care, referring Health Net Access members only to participating providers in compliance with Health Net Access' written policies and procedures
- obtaining current insurance information from the member
- cooperating with Health Net Access in connection with health plan performance of utilization management and quality improvement activities, including prior authorization of necessary services and referrals
- informing the member that referral services may not be covered by Health Net Access when referring to nonparticipating providers
- providing Health Net Access with medical record information if requested for a member for processing application for coverage; for prior authorizing services or processing claims for benefits; or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. (Health Net Access has a valid signed authorization from our members authorizing any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or other insurance information exchange to release information to Health Net Access if requested. Participating providers may obtain a copy of this authorization by contacting Health Net Access. Health Net Access does not reimburse for the cost of retrieval, copying and furnishing of medical records
- cooperating with any authorized Health Net Access business associate who may need to access member records that may include payment or medical records to determine the proper application of benefits, as well as the propriety of payments (including any claims payment recovery actions performed on behalf of Health Net Access)
- in the event of provider termination, cooperating with Health Net Access and other participating providers to provide or arrange for continuity of care to members undergoing an active course of treatment, subject to the requirements and limitations of Arizona statutes
- operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), the anti-kickback statute (section 1128B(b)) of the Social Security Act, and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164

Refer to the *PPA* for additional information about provider responsibilities.

## Provider right to advocate on behalf of the member

Health Net Access must ensure that its providers, acting within the lawful scope of their practices, are not prohibited or otherwise restricted from advising or advocating, on behalf of members who are the providers' patients, for the following:

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- any information the member needs in order to decide among all relevant treatment options
- the risks, benefits and consequences of treatment or non-treatment
- the member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

## Nondiscrimination

Health Net Access and its participating providers must not discriminate against any provider that serves high-risk populations or specializes in conditions that require costly treatment.

All organizations that provide services to Medicaid members, including Health Net Access and its participating providers, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), and all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

---

# PRIOR AUTHORIZATION PROCEDURES

## Referrals

A referral is an agreement between the member's assigned PCP and a designated specialist. PCPs may make a referral by telephone, fax or in writing to the requested rendering specialist. Any available referral form may be used; however, providers may download an electronic copy of the Health Net Access Referral Form by visiting the Forms section in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com) or by contacting the Health Net Access provider network representative.

Specialists may refer to other specialists as long as the referral is consistent with the condition originally referred to them by the member's PCP. Health Net Access-participating specialists can provide most specialty services, and a referral outside the network is rarely necessary. When making a referral, the provider must adhere to the following guidelines:

- If a member requires specialty services, available specialists in the medical group/independent practice association's (IPA's) specialty network must be utilized as the primary resource.
- If a member requires services that cannot be provided by the medical group/IPA's specialty network, Health Net Access' entire network may be available to the member; however, prior authorization is required to use a provider outside of the medical group/IPA's specialty network.
- Consider the member's input regarding proposed treatment plans.

If Health Net Access' network of specialists cannot perform the services required, prior authorization must be obtained to refer outside of Health Net Access' network.

## Prior authorization

Prior authorization is the process by which Health Net Access determines in advance whether a service is covered, based on the initial request and information received from the provider.

Reimbursement is based on the accuracy of the information received with the prior authorization request, on whether the service is substantiated through concurrent and medical review, and/or on whether the claim meets claim submission requirements. All other coverage requirements must also be met in order for a claim to be eligible for payment.

Prior authorization does not replace the participating provider's judgment with respect to the member's medical condition or treatment requirements.

Utilization management decisions are based on appropriateness of care and service and the member's eligibility. Health Net Access does not reward individuals for issuing denials of coverage or service care. There are no financial incentives or other rewards for decisions that result in underutilization.

Providers are responsible for obtaining prior authorization; the member must not be billed if the provider fails to obtain prior authorization before performing services.

## Requests

Completion of the Request for Prior Authorization form is the primary method Health Net Access uses to manage the referral process for providers directly contracting with Health Net Access. It enables

Health Net Access to monitor the care provided to members and provides instructions to the specialist regarding authorized services.

Providers can submit the Request for Prior Authorization form to request standard or urgent authorization. Requests for prior authorization for services must be directed to the Health Net Access Prior Authorization Department.

### *Review and approval process*

Health Net Access uses established clinical criteria guidelines for making medical determinations based on medical necessity. Health Net Access' utilization management and prior authorization criteria are based on sound clinical evidence. Prior to Health Net Access making a determination based on medical necessity, a member must meet all eligibility and benefit coverage requirements.

Health Net Access adopted medical necessity criteria for medical necessity review, including all regulatory criteria for medical necessity that have been established for the program, which may include the following evidence-based guidelines:

- InterQual®
- Medicare national and local coverage guidelines
- National Institutes of Health (NIH) consensus statements
- National Guidelines Clearinghouse (NGC)
- American Medical Association (AMA)
- American Psychological Association (APA)
- Agency for Healthcare Research and Quality (AHRQ)
- American Association of Health Plans (AAHP) (online at [www.guidelines.gov](http://www.guidelines.gov)) as approved by the Medical Practice Committee and the Quality Council
- Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual content
- Arizona Department of Health Services; Division of Behavioral Health Services/Clinical Guidance Tools

Criteria are reviewed at least annually with input from network practitioners and updated as necessary.

Medical directors are always available to discuss prior authorization requests and denials with the requesting physician. Providers may contact the Prior Authorization Department to reach medical directors. Denial letters include criteria used in a decision that results in a denial determination and an explanation of the appeal process. A copy of the criteria utilized in the decision is available upon request.

The Prior Authorization Department is available to provide support and assistance to physicians with issues regarding coverage, discharge planning and benefit information.

### *Responses*

Upon receipt of all necessary information, Health Net Access processes the following requests within the following time frames:

- expedited requests – 3 business days
- standard, routine requests – 14 calendar days

If Health Net Access needs additional information, the request determinations may be extended up to 14 calendar days, when justified.

In the event the request fails to meet established criteria and is denied, a letter is automatically sent to the member, the requesting physician and the PCP, if applicable. The letter includes an explanation of the appeal process and how a member or applicable provider can obtain a copy of the criteria utilized in the decision. The physician may discuss the case with a medical management reviewer or physician reviewer by contacting the Health Net Access Prior Authorization Department at 1-888-926-1736.

### *Services requiring prior authorization*

Providers are encouraged to access the Health Net Access Provider Operations Manual online when possible for the most current services, procedures and equipment requiring prior authorization for Health Net Access members. The Provider Operations Manual is available in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

### *Emergencies*

Health Net Access provides coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity, such that a layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition.

Emergency services are covered both in-network and out-of-network and do not require prior authorization. In accordance with AHCCCS and 42 CFR 438.114, emergency room screening and stabilization services do not require prior approval to be covered by Health Net Access.

### *Behavioral health services*

Based on medical necessity, authorization of services is required for the following services:

- inpatient behavioral health or detoxification, including hospital, psychiatric hospital, subacute facility, and residential treatment center services or related bed holds
- psychological and neuropsychological testing
- electroconvulsive therapy (ECT)

Authorization is not required for other services, including outpatient visits, as long as the member meets medical necessity criteria based on population-based care shaping with the treatment providers.

Services that do not require prior authorization include:

- office or home visits for evaluations and/or counseling
- crisis intervention services and behavioral health professional services in an emergency room
- emergency transportation services via air or ground
- telehealth and telemedicine services for services that do not require authorization
- multisystemic therapy for juveniles (MST)
- methadone maintenance treatment
- developmental testing
- behavioral health day programs – supervised, therapeutic community treatment and day programs

- behavioral health rehabilitation services – personal care services, home care training, unskilled respite care, supported housing
- behavioral health support services – skills training; developmental, cognitive and psychosocial rehabilitation; health promotion; psychoeducational services; and ongoing support to maintain employment
- home passes

## Prescription medication prior authorization requests

Some in-office injectables and medications listed on the *Health Net Access Drug List* may require prior authorization. In some cases, this may include medications that the member has been court-ordered to receive. Prior authorization for court-ordered injectable medications should be submitted as expedited requests, as needed. Physicians or pharmacies must obtain prior authorization by telephone or fax through Health Net Pharmaceutical Services (HNPS). Prior authorization request turnaround times are as follows:

- standard request is less than 72 hours
- expedited request is less than 24 hours

If approved, the approval notice is faxed to the physician or pharmacy.

## Notification of admissions

All elective, urgent and emergency inpatient and outpatient observation admissions, and skilled nursing facility (SNF) admissions must be reported to Health Net Access' Hospital Notification Unit at 1-888-926-1736 within 24 hours or the next business day, unless otherwise stated in the *PPA*. Elective inpatient admissions require authorization from the Health Net Access Prior Authorization Department.

For behavioral health admissions for Health Net Access General Mental Health/Substance Abuse (GMH/SA) members, fax or call in admission notifications to the Health Net Access Hospital Notification Unit.

Notify Health Net Access of a newborn within 24 hours or no later than three days of delivery by contacting the Hospital Notification Unit at 1-888-926-1736.

Services denied for late or non-notification are considered nonreimbursable and may not be billed to the member.

### *Required information*

Providers must submit the following information to notify Health Net Access of a member's admission:

- facility name
- name of caller reporting admission
- telephone number of caller reporting admission
- member's full name
- member's Health Net Access ID
- member's date of birth
- admission date
- admission time
- room number (for emergency room (ER) notifications there may not be a room number assigned)
- admit type (how member arrived at inpatient stay – elective, direct, urgent, emergent)

- admitting diagnosis or chief complaint
- type of admission (medical, surgical, observation, detox, telemetry, or intensive care)
- admitting or attending physician (ER physicians cannot be identified as they are not going to follow the patient during their facility stay. When notifying Health Net Access of a newborn admission, identify the admitting pediatrician)
- other insurance if Health Net Access is not primary carrier
- status of admission (inpatient, skilled nursing, sub-acute rehabilitation)

### *Notification process*

When Health Net Access is notified of hospital admissions, the hospital notification unit staff verifies eligibility, hospitalist, behavioral health provider, or PCP assignment and whether the service requires prior authorization. Health Net Access enters the notification into the system to generate a case tracking number and issues the number to the caller. If systems are unavailable, a temporary tracking number is assigned. The facility is responsible for obtaining the permanent tracking number by contacting Health Net Access prior to claim submission.

All elective detox, urgent and emergency inpatient, and skilled nursing facility (SNF) admissions must be reported to the Health Net Access Hospital Notification Unit within 24 hours or the next business day, unless otherwise stated in the facility contract.

Health Net Access may review services after they are provided to determine medical appropriateness. Payment is not made for services that are inappropriate, not a covered benefit or not medically necessary.

## Questions

Providers who have questions regarding prior authorization may contact the Prior Authorization Department at 1-888-926-1736 for assistance.

Comprehensive prior authorization information is available in the Health Net Access Provider Operations Manual available in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

This page intentionally left blank

---

# HEALTH CARE ACCESS AND COORDINATION

## Early and Periodic Screening, Diagnosis, and Treatment

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive child health program to prevent, treat, correct, and improve physical and mental health problems for Medicaid members under age 21. The EPSDT program allows for periodic medically necessary screening, vision, hearing, and dental services. Based on the member's identified health care needs, diagnostic and treatment services are provided to treat, correct or ameliorate a defect, or a mental or physical illness or condition by the appropriate provider or organization. EPSDT services are designed to assist children in gaining access to necessary medical, social, educational, and other services.

### *Requirements for EPSDT providers*

EPSDT participating providers must:

- Provide EPSDT services in accordance with Section 42 USC 1396d (a) and (r), 1396a (a) (43), 42 CFR 441.50 et seq. and Arizona Health Care Cost Containment System (AHCCCS) rules and policies
- Provide and document EPSDT screening services in accordance with EPSDT and dental periodicity schedules
- Refer members for follow-up, diagnosis and treatment (initiated within 60 days of screening)
- Document in the member's medical record the member's or legal guardian's decision not to use EPSDT services or receive immunizations
- Provide health counseling and education at the initial and follow-up visits
- Schedule the next appointment at the time of the current visit
- Refer members to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program
- Refer members to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Arizona Early Intervention Program (AzEIP) and Head Start, as appropriate
- Initiate and coordinate referrals to behavioral health providers as necessary

### *Care coordination*

Primary care physicians (PCPs), and obstetricians (OBs) acting as PCPs during members' maternity, in their care coordination roles, refer Health Net Access members assigned to them for specialty treatments and services, as necessary. PCPs ensure coordinated quality care that is efficient and cost-effective. PCP responsibilities include, but are not limited to:

- Supervision of physician extenders, ongoing care and the coordination of all services their members receive
- Verification of any suspected serious medical condition, such as heart murmur, scoliosis and developmental problems. If needed services fall outside the PCP's scope of practice, appropriate referrals must be made with the initiation of treatment to occur within 60 days from the health assessment appointment when the condition was identified
- Referral of potentially eligible children to CRS
- Providing the appropriate authorization to have the services provided by a nonparticipating provider when the member requires services that are unavailable in Health Net Access' provider network

- Requesting care coordination from Health Net Access' Maternal Child Health (MCH) manager/EPSDT coordinator if indicated for the member's condition
- Coordinating care and services with appropriate state agencies for EPSDT-eligible members (such as CRS, AzEIP, WIC, Vaccines for Children (VFC), Arizona State Immunization Information System (ASIS), and Head Start)

### *Screenings*

EPSDT screenings must include:

- A complete health and development history, including assessment of both physical, nutritional and mental health development
- A comprehensive unclothed physical examination, including assessment of physical growth
- Immunizations, if needed
- Laboratory tests appropriate to age and risk, including lead testing, tests for anemia and testing for sickle cell trait, when appropriate
- Health education and guidance appropriate to the person's age and health status
- A dental screening, including inspection of mouth, teeth and gums
- Hearing and vision screening, and speech testing
- Tuberculin test, as appropriate to age and risk

All children with dental problems must be referred directly to a dentist for care and the referral documented on the EPSDT Tracking form.

Providers may download an electronic copy of the EPSDT Tracking form from the Forms section in the Provider Library on the provider website at [provider.healthnet.com](http://provider.healthnet.com).

### *Documentation requirements*

All EPSDT participating providers who deliver care to members under age 21 must complete the appropriate EPSDT Tracking form. The EPSDT Tracking form is used for Medicaid members and to monitor compliance with EPSDT and dental periodicity schedules. Providers may utilize an electronic health record system, as long as the electronic documentation includes all elements present on the most current age appropriate EPSDT Tracking form. The provider who performed the screening must sign the tracking form and provide a valid National Provider Identifier (NPI) number (if an electronic medical record is used, it must include an electronic signature).

A copy of the EPSDT Tracking form must be filed in the member's medical record. In addition, EPSDT exams, services and findings must be documented in the medical record progress notes.

A second copy must be sent to the Health Net Access Encounters Department at:

PO Box 419071  
Rancho Cordova, CA 95741  
Fax: 1-866-684-7363

## Vaccines for Children program

The EPSDT program covers all child and adolescent immunizations. Participating providers must coordinate with the Arizona Department of Health Services (ADHS) VFC program. The VFC program is a federally and state-funded program providing free vaccines in bulk to physicians serving Medicaid-eligible children under age 19. Immunizations must be provided according to the Advisory Committee

on Immunization Practices (ACIP) recommended schedule. Health Net Access does not reimburse participating providers for vaccines covered by the VFC program. Health Net Access reimburses for the administration of these immunizations only.

Providers must enroll or re-enroll annually with the VFC program in accordance with AHCCCS by December 31.

Arizona state law requires providers to report all immunizations given to children under age 19 at least monthly to the ADHS Immunization Registry; however, it is recommended that high-volume immunization providers report more frequently. Providers must complete the form online or complete a hard copy and mail it to ASIIS, a central database maintained by the ADHS to record all immunizations, at:

Arizona State Immunization Information System  
150 N. 18<sup>th</sup> Avenue, #120  
Phoenix, AZ 85007

Providers may call ASIIS at 1-877-491-5741 for technical support, to request a copy of the paper reporting form, or for assistance using the Web application.

## Arizona Early Intervention Program

AHCCCS and AzEIP jointly developed procedures for the coordination of services under Early Periodic Screening, Diagnostic and Treatment (EPSDT) and AzEIP to ensure the coordination and provision of EPSDT and AzEIP services.

### *PCP-Initiated services*

When concerns about a child's development are initially identified by the child's PCP, the PCP requests an evaluation and, if medically necessary, approval of services from Health Net Access.

Evaluation/Services: Health Net Access may pend approval for services until the evaluation has been completed by the provider and may deny services if the PCP determines there is no medical need for services based on the results of the evaluation.

- Requests for services from PCPs, licensed providers or the AzEIP service coordinator based on the Individual Family Service Plan (IFSP) must be reviewed for medical necessity prior to authorization and reimbursement.
- If services are approved, Health Net Access authorizes the services with a Health Net Access participating provider, whenever possible, and notifies the PCP (requesting provider if other than the PCP) that (a) the services are approved, and (b) identifies the provider that has been authorized, the frequency, duration, and the service begin and end dates.
- Health Net Access follows the Code of Federal Regulation 42 438.210 for completion of prior authorization requests:
  - Health Net Access provides a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of a standard authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if Health Net Access justifies a need for additional information and the delay is in the member's best interest.
  - In the event that a provider indicates or Health Net Access determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or

regain maximum function, Health Net Access makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires no later than three business days following the receipt of the authorization request (date of receipt of request), with a possible extension of up to 14 calendar days if the member or provider requests an extension or if Health Net Access justifies a need for additional information and the delay is in the member's best interest.

- Referral to AzEIP: After completing the evaluation, the provider who conducted the evaluation submits an evaluation report to the PCP (requesting provider if other than the PCP) and the Health Net Access Prior Authorization Department for authorization of medically necessary services:
  - If the evaluation indicates that the child scored two standard deviations below the mean, which generally translates to AzEIP's eligibility criteria of 50 percent developmental delay, the child continues to receive all medically necessary EPSDT covered services through Health Net Access. The Health Net Access EPSDT coordinator refers the child to AzEIP for non-medically necessary services that are not covered by Medicaid, but are covered under Individuals with Disabilities Education Act (IDEA) Part C.
  - If the evaluation report indicates that the child does not have a 50 percent developmental delay, the EPSDT coordinator continues to coordinate medically necessary care and services for the child.

Health Net Access and AzEIP continue to coordinate services for Medicaid children who are eligible for and enrolled in both AzEIP and Medicaid. The EPSDT coordinator assists the parent or caregiver in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services are provided by Health Net Access's participating provider (or AzEIP service provider reimbursed by Health Net Access) until the services are determined by the PCP and provider to no longer be medically necessary.

### *AzEIP-initiated service requests*

When concerns about a Medicaid enrolled child's development are initially identified by AzEIP:

- If an EPSDT-eligible child is referred to AzEIP, AzEIP screens and, if needed, conducts an evaluation to determine the child's eligibility for AzEIP. AzEIP obtains parental consent to request and release records to and from Health Net Access and the child's PCP.
- The PCP reviews all AzEIP documentation and determines which services are medically necessary based on review of the documentation.
- The PCP takes no longer than 10 business days from the date the EPSDT coordinator faxes the documentation to the PCP to determine which services are medically necessary and returns the signed AzEIP AHCCCS Member Service Request form (Exhibit 430-4) to the EPSDT coordinator.
- The PCP will determine:
  - The requested services are medically necessary:
    - Within two business days, the EPSDT coordinator sends the completed AzEIP AHCCCS Member Service Request form (Exhibit 430-4) to the AzEIP service coordinator and PCP advising them that: (a) the services are approved, and (b) identifying the provider that has been authorized, the frequency, duration, and the service begin and end dates.
    - Health Net Access authorizes services with a Health Net Access participating provider whenever possible.
    - AzEIP providers may only be reimbursed (a) if they are AHCCCS registered, and (b) for the categories of services for which they are registered and that were provided. Billing must be completed in accordance with AHCCCS guidelines.

- When services are determined by the PCP and service provider to be no longer medically necessary, the AzEIP service coordinator implements the process for amending the IFSP, which may include (a) non-medically necessary services covered by AzEIP, and (b) changes made to IFSP outcomes and IFSP services, including payer, setting, etc.

The AzEIP service coordinator, family and other IFSP team members review the IFSP at least every six months or sooner if requested by any team member. If services are changed (deleted or added) during an annual IFSP or IFSP review, the AzEIP service coordinator notifies the EPSDT coordinator and PCP within two business days of the IFSP review. If a service is added, the AzEIP service coordinator's notification to the EPSDT coordinator initiates the process for determining medical necessity and authorizing the service as outlined above.

## Parent's Evaluation of Developmental Screening tool

PCPs must use the Parent's Evaluation of Developmental Screening (PEDS) tool for developmental screening at each visit for neonatal intensive care unit (NICU)-discharged members from birth to age eight. The PEDS tool is designed for use in conjunction with the well-child EPSDT visit for further assessment of developmental milestones, including social, emotional and cognitive development for NICU graduates. All PCPs must complete PEDS tool training in order to use the tool and bill Health Net Access. PEDS tool-trained providers are reimbursed for using the tool with members who are graduates from the NICU. The PEDS tool can be obtained by contacting Health Net Access' MCH manager/ EPSDT coordinator at (602) 794-1539.

The MCH manager/EPSDT coordinator:

- Works with providers to ensure utilization of the AHCCCS-approved standard developmental screening tools and complete training in the use of the tools.
- Assists families with NICU-discharged children in the selection of PEDS-trained providers.
- Notifies PCPs when a NICU-discharged member is assigned to their panel.
- Monitors providers for compliance with training and use of the PEDS tool.
- Implements specific interventions to improve provider compliance of PEDS training and use.
- Ensures that the newborn screening tests are conducted, including initial and second screening, in accordance with 9 AAC 13, Article 2.

## Maternity care provider requirements

Maternity care services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. In addition, related services such as outreach, education and family planning services are provided whenever appropriate, based on the member's current eligibility and enrollment.

All maternity care services must be delivered by qualified physicians and non-physician practitioners. Provider requirements for maternity care are as follows:

- Physicians and practitioners must adhere to the American Congress of Obstetricians and Gynecologists (ACOG) standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment
- Licensed midwives must provide services within their scope of practice

- All maternity care providers must ensure that:
  - They notify Health Net Access promptly when members have tested positive for pregnancy.
  - High-risk members have been referred to a qualified physician and are receiving appropriate care.
  - Members are educated about health behaviors during pregnancy, including the importance of proper nutrition; smoking cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections (STIs); the physiology of pregnancy; risk assessment and screening for lead exposure, which, in pregnancy, can adversely affect both mother and fetus health; the process of labor and delivery; breastfeeding; other infant care information, including selecting a pediatric provider for the baby; and postpartum follow-up.
  - Member medical records are appropriately maintained and document all aspects of the maternity care provided.
  - Members are informed of voluntary HIV testing and that counseling is available if the test is positive or determinant.
  - Members are referred for support services to WIC, as well as other community-based resources, in order to support healthy pregnancy outcomes. Members must be notified that in the event they lose eligibility for services, they may contact the Arizona Department of Health Services Bureau of Women’s and Children’s Health Hotlines for referrals to low- or no-cost services at:
    - Pregnancy and breastfeeding: 1-800-833-4642
    - Children’s information center: 1-800-232-1676
    - WIC: 1-866-229-6561
- Postpartum services must be provided to members within 60 days of delivery.

## Behavioral health coordination

Primary care physicians (PCPs) should coordinate care with behavioral health providers as follows:

- provide all necessary medical records and documentation related to the diagnosis and care of the behavioral health condition that resulted in a referral within 10 business days of a request from the behavioral health provider. At a minimum, the exchange of information must include:
  - diagnosis
  - medication
  - laboratory results
  - last PCP, emergency and hospital visits
- document the referral and other pertinent information in the member’s medical record. PCPs must initial or sign records received from Health Net Access, Regional Behavioral Health Authority (RBHA), or Tribal/Regional Behavioral Health Authority (T/RBHA) providers as evidence that the PCP has reviewed the documents. Providers must place information received from the behavioral health provider in the member’s medical record
- respond to requests to coordinate with specialists

## Behavioral health coverage overview

Health Net Access provides integrated behavioral and physical health services for dual-eligible General Mental Health and Substance Abuse (GMH/SA) members in Maricopa County, Arizona. For members who are eligible for both Medicare and Medicaid, Health Net Access adheres to regulatory standards established by the Arizona Health Care Cost Containment System (AHCCCS) and the

Arizona Department of Health Services' Division of Behavioral Health Services (ADHS/BBHS) in order to provide a consistent, quality integration with medical services.

The Health Net Access program has a dedicated team that handles medical case management for all Health Net Access members. Covered services may be either Medicare-prime or Medicaid-prime, but all dual-eligible members are provided coordinated care and services to promote integration of physical and behavioral health. Children and those individuals with serious mental illness (SMI) receive their behavioral health services through Arizona's RHBA and T/RBHA.

GMH/SA covered services (Medicare-prime; Health Net Access Medicaid-secondary):

- office visits (license type limitations for Medicare)
- IP professional services or consultations
- medication management
- telehealth and telemedicine services
- psychological/neuropsychological testing
- lab/radiology/imaging
- language assistance
- transportation (emergency and non-emergency)
- emergency/crisis services
- ambulance services
- Medicare-covered IP days (MH and detox)
- electroconvulsive therapy (ECT)

Health Net Access Medicaid services (not covered by Medicare):

- licensed professional counselor (LPC) and licensed marriage and family therapist (LMFT) office visits (and other license types not allowed by Medicare)
- exhausted Medicare inpatient days
- residential treatment center services
- exhausted non-emergency transportation
- supervised behavioral health treatment and day programs (partial programs)
- methadone maintenance treatment
- home pass
- bed hold
- biofeedback

Not covered by Health Net Access (Medicare-only services):

- transcranial magnetic stimulation (TMS)
- autism/ABA for GMH/SA age group
- traditional partial hospitalizations (full and half day)
- intensive outpatient treatment for mental health conditions

Health Net Access provides behavioral health services 24 hours a day, seven days a week, including case management and coordination of care. Individuals who are not dually eligible, children under age 18 and members with SMI will continue to receive treatment through the Regional Behavioral Health Authority or the Tribal/Regional Behavioral Health Authority (T/RBHA). Health Net Access coordinates with the RBHA or T/RBHA providers to ensure care is provided as needed.

Dual-eligible members who receive services from Health Net Access can have their Medicare coverage with Health Net Arizona, Medicare fee-for-service (FFS) (Original Medicare) or another Medicare Advantage health plan. Services covered by Medicare are the primary responsibility of the Medicare plan to cover with Health Net Access as a secondary source. Services in scope (i.e., covered Medicaid services), and not covered by Medicare, are covered and managed by Health Net Access.

## QUICK REFERENCE

<b>Contacts</b>	
Name/Topic	Contact Information
<b>APPEALS AND GRIEVANCES (MEMBER)</b>	Health Net Access Member Appeals and Grievances Department Attention: Appeals and Grievances Manager PO Box 10341 Van Nuys, CA 91410 Fax: 1-855-844-0687
<b>ARIZONA EARLY INTERVENTION PROGRAM (AzEIP)</b>	(602) 532-9960 <a href="http://www.azdes.gov/AzEIP">www.azdes.gov/AzEIP</a>
<b>ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)</b> (member eligibility verification)	(602) 417-7200 <a href="http://azweb.statemedicaid.us">azweb.statemedicaid.us</a>
<b>ARIZONA STATE IMMUNIZATION INFORMATION SYSTEM (ASIIS)</b>	150 North 18 <sup>th</sup> Avenue, #120 Phoenix, AZ 85007 1-877-491-5741 <a href="http://asiis.azdhs.gov">asiis.azdhs.gov</a>
<b>BEHAVIORAL HEALTH (MERCY MARICOPA INTEGRATED CARE, THE REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) IN MARICOPA COUNTY)</b>  For members who are not dual-eligible and those with SMI	1-800-564-5465 <a href="http://www.mercymaricopa.org">www.mercymaricopa.org</a>
<b>BEHAVIORAL HEALTH COORDINATOR</b>	(602) 794-1493
<b>HEALTH NET ACCESS BEHAVIORAL CASE MANAGEMENT DEPARTMENT</b>	Fax: 1-855-825-6146 <a href="mailto:CMAccess/GRP/HNCA/HNT@healthnet.com">CMAccess/GRP/HNCA/HNT@healthnet.com</a>
<b>CLAIMS DISPUTES (PROVIDER)</b>	Health Net Access, Inc. Attention: Provider Disputes 1230 West Washington Street, Suite 401 Tempe, AZ 85281
<b>CLAIMS PAPER SUBMISSION AND RESUBMISSION</b>	Health Net Access, Inc. PO Box 14095 Lexington, KY 40512
<b>CLAIMS PROVIDER STATE FAIR HEARING</b>	Health Net Access, Inc. Attention: Provider State Fair Hearings 1230 West Washington Street, Suite 401 Tempe, AZ 85281
<b>CLAIMS RECOVERY/REFUNDS</b>	Health Net Access Overpayment Recovery Department Health Net of Arizona Claims Refunds File 749801 Los Angeles, CA 90074-9801

<b>Contacts</b>	
Name/Topic	Contact Information
<b>EPSDT TRACKING FORM</b>	Health Net Access Encounters Department PO Box 419071 Rancho Cordova, CA 95741 Fax: 1-866-684-7363
<b>FRAUD, WASTE AND ABUSE</b>	Health Net, Inc. Special Investigations Unit PO Box 2048 Rancho Cordova, CA 95741-2048 1-800-977-3565
<b>HEALTH NET ACCESS OFFICES</b>	Health Net of Arizona 1230 W. Washington St. #401 Tempe, AZ 85281
<b>HEALTH NET ACCESS CASE MANAGEMENT DEPARTMENT</b>	1-800-977-7281
<b>MATERNAL CHILD HEALTH (MCH) MANAGER/EPSDT COORDINATOR</b>	(602) 794-1539
<b>NOTIFICATION OF ADMISSIONS</b>	1-888-926-1736 Fax: 1-855-764-8513
<b>PHARMACEUTICAL SERVICES</b> (prescription medication prior authorization)	1-800-410-6565 Fax: 1-800-977-4170
<b>PREFERRED HOME CARE</b>	1-800-636-2123
<b>PRIOR AUTHORIZATION</b>	1-888-926-1736 Fax: 1-855-764-8513 (available 24/7)
<b>PROVIDER SERVICES</b> <ul style="list-style-type: none"> <li>• Eligibility</li> <li>• Claims</li> <li>• Benefit verification</li> <li>• Third-party recovery</li> <li>• Coordination of benefits</li> <li>• Refunds</li> <li>• Appeals and grievances (member)</li> </ul>	1-888-788-4408
<b>PROVIDER WEBSITE</b>	provider.healthnet.com
<b>QUALITY IMPROVEMENT DEPARTMENT</b>	(602) 794-1661 Fax: 1-866-524-5734 AHCCCS_Notification@healthnet.com
<b>SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)</b>	1-866-229-6561
<b>VACCINES FOR CHILDREN (VFC)</b>	(602) 364-3642

This page intentionally left blank

This page intentionally left blank



*For more information, please contact:*

**Health Net Access, Inc.**

1230 W. Washington Street, Ste. 401

Tempe, AZ 85281

The Provider Reference Guide is not intended to replace the Health Net Access Provider Operations Manual. The Health Net Access Provider Operations Manual may be obtained by contacting your provider relations representative or by visiting our website at [provider.healthnet.com](http://provider.healthnet.com).

Health Net Access, Inc. is a subsidiary of Health Net, Inc. Health Net is a registered service mark of Health Net, Inc. All rights reserved.