Health Net Provider Library Arizona Physician or Practitioner Health Net Access
Effective 11/01/2016

Operations Manuals

Health Net Overview

Found in: Operations Manuals Effective 07/01/2013

Health Net of Arizona, Inc. is a subsidiary of Health Net, Inc. (NYSE:HNT).
Health Net, Inc. is a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Its mission is to help people be healthy, secure and comfortable. Health Net provides and administers health benefits to approximately 5.4 million individuals across the country through group, individual, Medicare (including the Medicare prescription drug benefit commonly referred to as "Part D"), Medicaid, U.S. Department of Defense, including TRICARE, and Veterans Affairs programs. Through its subsidiaries, Health Net also offers behavioral health, substance abuse and employee assistance programs, managed health care products related to prescription drugs, managed health care product coordination for multi-region employers, and administrative services for medical groups and self-funded benefits programs. Health Net of Arizona has been serving Arizonans since 1981.

Health Net Access

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

Disclaimer

Health Net participating providers are required to comply with applicable federal and state laws and regulations and Health Net policies and procedures. The contents of Health Net's operations manuals are supplemental to the *Provider Participation Agreement* (*PPA*) and its addendums. When the contents of Health Net's operations manuals conflict with the *PPA*, the *PPA* takes precedence.

Benefits

Found in: Operations Manuals Effective 01/01/2003

Audiology

Found in: Operations Manuals > Benefits Effective 07/01/2013

Audiology Coverage

Found in: Operations Manuals > Benefits > Audiology Effective 07/01/2013

Health Net Access covers medically necessary audiology services, within certain limitations, to evaluate hearing loss and rehabilitate persons with hearing loss through means other than medical/surgicalprocedures.

Covered services include:

- Exams or evaluations for hearing aids
- Exams or evaluations for cochlear implants
- Evaluations for prescription of speech-generating and non-speech-generating augmentative and alternative communicating devices
- Therapeutic service(s) for the use of speech-generating and non-speech-generating devices, including programming and modification, and devices such as hearing aids, cochlear implants, speech-generating and non-speech-generating

Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets federal requirements specified under 42 CFR 440.110.

Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license. Hearing aids, provided as a part of audiology services, are covered only for members under age 21 receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services or those enrolled in KidsCare. Health Net Access does not cover hearing aids for members ages 21 and older.

Arizona Health Care Cost Containment Services (AHCCCS) eliminated coverage of bone-anchored hearing aid (BAHA), also known as osseointegrated implants, and cochlear implants for members ages 21 and older. Supplies, equipment maintenance and repair of

component parts remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided when requesting prior authorization.

Behavioral Health

Found in: Operations Manuals > Benefits Effective 01/01/2003

Overview

Found in: Operations Manuals > Benefits > Behavioral Health Effective 05/19/2016

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) monitors and oversees the state behavioral health system. ADHS/DBHS contracts with the Regional Behavioral Health Authority (RBHA), and the Tribal/Regional Behavioral Health Authority (T/RBHA) for members who are American Indians, to provide covered behavioral health services to adults and children.

Effective October 1, 2015, dual-eligible members who are enrolled in both Medicare and Medicaid, and have? general mental health/substance abuse (GMH/SA) behavioral health needs are the responsibility of acute care plans, such as Health Net Access. Members may be aligned (both Medicare and Medicaid with the same plan) or unaligned (separate plans for Medicare and Medicaid). If the member is unaligned, the Medicaid acute care plan is the primary payer of behavioral health services. This does not include services for children under age 18 or individuals determined to have a serious mental illness (SMI). These members continue to receive services through the RBHA. When deemed medically necessary, comprehensive behavioral health services are covered for Health Net Access members.

Health Net Access covers the full continuum of GMH/SA services for dual-eligible members. Primary care providers (PCPs) continue to be responsible for providing general mental health services for the conditions listed below. When the member's diagnosis or behavioral health needs are beyond the scope of the PCP's practice, the member should be referred to a provider in the Health Net Access behavioral health provider network.

- attention deficit hyperactivity disorder (ADHD)
- anxiety
- depression
- postpartum depression

The Health Net Access behavioral health coordinator is available to assist in bridging the gap between Health Net Access and RHBA for non-dual-eligible members, regarding coordination of all services identified as medically necessary, including, but not limited to, referral of members requiring specialty behavioral health services and dispute resolution. PCPs may submit a referral for a SMI eligibility determination directly by contacting the Crisis Preparation and Recovery, Inc.'s SMI Evaluation Department.

Comprehensive GMH/SA services are available to Health Net Access dual-eligible members. A direct referral for a behavioral health evaluation can be made by any health care professional in coordination with the member's assigned PCP and case manager. Health Net Access members may also self-refer for all behavioral health services to RBHA. The level and type of behavioral health services are provided based on the member's strengths and needs and with respect to the member's culture.

Behavioral health services include, but are not limited to:

- behavior health case management (personal care, family support/home care training, peer support)
- behavioral health nursing services
- emergency behavioral health care
- emergency and non-emergency transportation
- evaluation and assessment
- individual, group and family therapy/ counseling
- inpatient hospital services
- non-hospital inpatient psychiatric facilities services (level I residential treatment centers and sub-acute facilities)
- lab and radiology services for psychotropic medication regulation and diagnosis
- opioid agonist treatment
- partial care (supervised, therapeutic and medical day programs)
- psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- psychotropic medication
- psychotropic medication adjustment and monitoring
- respite care (with limitations)
- rural substance abuse transitional agency services
- home care training to home care client
- behavioral health/substance abuse screenings
- wellness and recovery services

Behavioral Health Provider Types

Many provider types can typically provide behavioral health services for Health Net Access members. These may include, but are not limited to, the following licensed agencies and individuals:

- outpatient behavioral health clinics
- psychiatrists
- psychologists
- certified psychiatric nurse practitioners
- licensed clinical social workers
- licensed professional counselors
- licensed marriage and family therapists
- licensed independent substance abuse counselors
- residential treatment facilities
- behavioral health residential facilities.
- partial hospital programs
- intensive outpatient programs
- substance abuse programs
- inpatient hospital facilities
- community service agency

Alternative Living Arrangements

Health Net Access members may be eligible for the following alternative living arrangements:

- Behavioral health inpatient facility - this setting provides behavioral health treatment with 24-hour supervision. Services may include onsite medical services and intensive behavioral health treatment programs. These are often located in a locked hospital setting.
- Traumatic brain injury treatment facility - this setting provides treatment and services for people with traumatic brain injuries.
- Residential treatment center - this setting provides treatment for chemical dependency treatment, co-occurring disorders or acute psychiatric treatment, in a non-locked residential facility.

Emergency Services

Health Net Access benefits include behavioral health emergency services for members. If a member is experiencing a behavioral health crisis, providers should contact the Crisis Response Network. During a member's behavioral health emergency, a behavioral health hotline clinician may dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the situation and evaluate the member for behavioral health services. All medically necessary services are covered by Health Net Access.

Behavioral Health Screening

Members should be screened by their PCPs for behavioral health needs during routine or preventive visits, as required at each Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit for members under age 21.

Behavioral Health Appointment Standards

Health Net Access routinely monitors providers for compliance with appointment standards. The minimum standard requirements are:

- emergency - within 24 hours of referral
- routine - within 30 days of referral
- post-hospitalization - within 7 days of discharge

Behavioral Health Coordination and Provider Responsibilities

Found in: Operations Manuals > Benefits > Behavioral Health Effective 05/19/2016

It is critical that strong communication be maintained between behavioral health providers and the following:

- Primary care providers (PCPs) and other medical providers.
- Member's guardian, power of attorney and/or Public Fiduciary Department (if proper documentation is provided).
- Veterans office (when applicable).
- The court system, such as probation, parole, mental health court, Adult Protective Services, and Child Protective Services, as applicable.
- Other specialty providers involved in the member's care.

Information necessary for the member's treatment can be shared with the other party. This process begins once a member is identified as meeting medical necessity for seeing a behavioral health provider by the behavioral health coordinator. Information can be shared with other parties with written permission from the member or the member's guardian.

PCP Coordination of Care

The PCP and behavioral health provider must established communication once the PCP is informed his or her member is seeing a behavioral health provider. PCPs must maintain strong communication with the behavioral health provider. PCPs are expected to exchange any relevant information, such as medical history, current medications, diagnosis, and treatment within 10 business days of receiving the request from the behavioral health provider.

A medical provider must coordinate care with the behavioral health provider within a timely manner when he or she identifies a change in the member's health status. The update should include, but is not limited to, diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP must review all documentation from the behavioral health provider who is treating the member and documenting it in the member's medical record. All efforts to coordinate care on behalf of the member should also be documented in the member's medical record.

Medication

The PCP assesses member for psychotropic medication and reviews the recipient's profile in the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database when initiating a controlled substance (such as amphetamines, opiates, benzodiazepines, etc.) that will be used on a short-term or regular basis.

Prior Authorization Requirements and Process

Health Net Access requires prior authorization for certain outpatient behavioral health services and continued hospital stays to ensure medical necessity. Health Net Access makes authorization decisions within 14 days of receipt for a standard request, and within 3 business days of receipt for an expedited request. Unauthorized services are not reimbursed.

Authorization is not a guarantee of payment. To request authorization, providers must contact the Prior Authorization Department at 1-888-926-1736 prior to delivery of services. Explain the necessity for prior authorization, including the type of services to be delivered, frequency of services, and duration of services.

Family Involvement

Family involvement in a member's treatment is an important aspect to recovery. Studies have shown members who have family involved in their treatment tend to recover quicker, are less dependent on outside agencies, and rely less on emergency resources. Family is defined as any person related to the member biologically or appointed (step-parent, guardian and/or power of attorney). Treatment includes treatment planning, participation in counseling or psychiatric sessions, and providing transportation or social support to the member. Written permission is required to share member's personal health information.

Court-Ordered Treatment and Petition Process

Found in: Operations Manuals > Benefits > Behavioral Health Effective 05/19/2016

Certain situations require members to be petitioned through the mental health court.

Emergent Petition

An emergent petition is a request for involuntary commitment for psychiatric treatment due to the member being an immediate danger to himself/herself or others. An emergent petition can be completed by any clinical professional who has witnessed petitionable behavior and statements. A crisis team can be used to pursue an emergent petition as well as hospital staff.

Non-Emergent Petition

Non-emergent petitions apply to persistently and acutely disabled or gravely disabled (PAD/GD) members and are defined as follows:

- Gravely disabled (GD): Unable to take care of own basic needs.
- Persistently or acutely disabled (PAD): Likely to suffer severe mental or physical harm because of impaired judgment cause by a mental health condition.

Non-emergent petitions are filed by calling the Crisis Response Network and require at least two witnesses of the member's petitionable behavior and statements.

Members Determined to Need Court-Ordered Treatment

For members who are already under court-ordered treatment through the Mental Health Court, Health Net Access is responsible for tracking the status of the member's treatment and reports to the Mental Health Court as necessary. As such, treating providers must notify Health Net Access of any treatments or other appropriate status updates.

For non-dual-eligible members (Medicaid only), children under age 18, and members with serious mental illness (SMI), these services continue to be provided by the Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (T/RBHA) and are excluded from Health Net Access coverage responsibilities. Behavioral health services are described in Title XIX and Title XXI of the ADHS/DBHS Division.

All behavioral health services are carved-out and excluded from coverage under Health Net Access' Arizona Health Care Cost Containment System (AHCCCS) acute care contract. Other than behavioral health services rendered by the Health Net Access contracting primary care provider (PCP), this exclusion includes outpatient and inpatient behavioral health services. Health Net Access is not responsible for reimbursement of inpatient facility and professional behavioral health services to hospitalized members with primary behavioral health diagnoses. Reimbursement is unrelated to the bed or floor where the member is placed.

AHCCCS assigns each Health Net Access-enrolled member into a RBHA or T/RBHA based on the member's residential ZIP code. Health Net Access PCPs may provide behavioral health services within the scope of their practice (such as to treat ADHD, anxiety, depression, and postpartum depression) and coordinate referrals for members requiring specialty and inpatient behavioral health services. Health Net Access provides coordination of care as needed by collaborating with the member/guardian, support system, PCP, and clinical team, to initiate appropriate referrals. Health Net Access' behavioral health coordinator is available to facilitate referrals and to assist the PCP in maintaining continuity of care for the member. Health Net Access PCPs coordinate all services identified as medically necessary, including referral of members requiring specialty behavioral health services to RBHA, T/RBHA or to the appropriate provider.

Court-Order Definitions

Mental disorder: deemed by ARS Title 36 as follows: A substantial disorder of the person's emotional processes, thought, cognition or memory.

Danger to others (DTO) [ARS §36-501-4]: Judgment of a person having a mental disorder is so impaired that he/she is unable to understand his need for treatment and as a result of his/her mental disorder, his/her continued behavior can reasonably be expected, on the basis of a competent medical opinion, to result in serious physical harm.

Danger to self (DTS) [ARS §36-501-5]: Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious treat thereof, or if the threat is expected that it will be carried out in light of context and previous acts and which as a result of a mental disorder will, without hospitalization, result in serious physical harm or serious illness to the person except that behavior which establishes only the condition of Gravely Disabled.

Gravely disabled (GD) [ARS §36-501-15]: Condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he/she is unable to provide for his/her basic physical needs.

Persistently or acutely disabled (PAD) [ARS §36-501-29]: Severe mental disorder, which:

1. If not treated has a substantial probability of causing the person to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality;
2. Substantially impairs the person's capacity to the extent they are incapable of understanding and expressing an understanding of the consequences of accepting treatment as well as the alternatives to the particular treatment after the advantages, disadvantages, and alternatives are explained; and,
3. Has a reasonable prospect of being treatable by outpatient, inpatient, or combined treatment.

Exclusions to what constitutes a serious mental illness: the person is primarily disabled due to drug abuse, alcoholism, or mental retardation; declining mental abilities that accompany impending death; or character and personality disorders characterized by life-long and deeply ingrained anti-social behaviors that can be reasonably expected, on the basis of competent medical opinion, to result in serious physical harm.

Emergency Services

Found in: Operations Manuals > Benefits > Behavioral Health Effective 05/19/2016

Health Net Access is responsible for all emergency medical services, including triage, physician assessment, diagnostic tests, ambulance transportation, and other medically necessary transportation provided to Health Net Access members.

For dual-eligible members, Health Net Access is responsible for medically necessary professional psychiatric consultations in emergency department or inpatient settings and reimburses ambulance transportation or other medically necessary transportation provided to members requiring behavioral services after medical stabilization.

For Medicaid-only members, the Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (T/RBHA) is responsible for medically necessary professional psychiatric consultations in emergency department or inpatient settings and reimburses ambulance transportation or other medically necessary transportation provided to a member requiring behavioral services after medical stabilization.

Health Net Responsibilities

Found in: Operations Manuals > Benefits > Behavioral Health Effective 08/11/2016

Health Net Access is responsible for:

- monitoring appropriate referral by primary care physicians (PCPs) for members in need of specialty and behavioral health services
- providing psychotherapeutic medications as prescribed by the PCP
- monitoring pharmacy utilization to ensure appropriate prescribing and dispensing
- facilitating and monitoring the coordination of care between the PCP and behavioral health providers
- providing transportation for the member's first behavioral health intake appointment and subsequent appointments
- providing Arizona Health Care Cost Containment System (AHCCCS) approved toolkits to PCPs for treatment of the diagnoses listed below. Toolkits are available on the provider website at www.healthnetaccess.com or by contacting the Health Net Access behavioral health coordinator.
    - adult ADHD
    - adult anxiety
    - adult depression
    - postpartum depression
    - child ADHD
    - child anxiety
    - child depression

- providing medically necessary covered behavioral health services for dual-eligible Medicare and Medicaid enrollees with General Mental Health/Substance Abuse (GMH/SA) and not determined to have a serious mental illness (SMI)

Medical Record Documentation

Found in: Operations Manuals > Benefits > Behavioral Health Effective 10/01/2015

Primary care physicians (PCPs) must establish a medical record when behavioral health information is received from Health Net Access, the Regional Behavioral Health Authority (RBHA) or Tribal/Regional Behavioral Health Authority (T/RBHA) provider, regardless of whether the PCP has seen the assigned member. The following information may be kept in an appropriate labeled file and must be associated with the member's medical record as soon as one is established:

- referral forms
- use of Arizona Health Care Cost Containment System (AHCCCS) behavioral health toolkit or other clinically approved tools or evidence-based guidelines
- release of information regarding substance abuse or HIV
- treatment information received from Health Net Access, RBHA or T/RBHA behavioral health provider, such as medication, diagnosis, laboratory results, hospital, or emergency visits

Medical records are randomly selected and audited annually for compliance. For audit questions, PCPs should contact the Health Net Access behavioral health coordinator.

PCP Treatment and Referrals

Found in: Operations Manuals > Benefits > Behavioral Health Effective 08/11/2016

Primary care physicians (PCPs) are responsible for identifying and treating, or making specialty medical referrals for, members' general medical conditions and behavioral health that cause or exacerbate psychological symptoms.

Treatment

PCPs may provide medication management services for select behavioral health disorders, such as anxiety, mild depression, postpartum depression, and attention deficit hyperactivity disorder (ADHD). Medication management services may include medication monitoring, prescriptions, laboratory services, and other diagnostic tests necessary to diagnose and treat behavioral disorders PCPs may use the Arizona Health Care Cost Containment System (AHCCCS) approved toolkits or other clinically approved tools or evidence-based guidelines for best practices addressing the treatment of these disorders. The AHCCCS toolkits include assessment tools, scoring instructions and recommended medication lists, and are available on the provider website at www.healthnetaccess.com or by contacting the Health Net Access behavioral health coordinator.

Referrals

PCPs are also responsible for coordinating referrals for members requiring specialty or inpatient behavioral health services through Health Net Access (for dual-eligible), the Regional Behavioral Health Authority (RBHA), or the Tribal/Regional Behavioral Health Authority (T/RBHA). Tribal members and veterans retain choice in where they access all or part of their services from, including Indian Health Services/638 facilities or the Veterans Administration. Behavioral health services for individuals determined to have a serious mental illness (SMI) are provided by the RBHA or T/RBHA and are excluded from Health Net Access coverage responsibilities.

PCPs are required to comply with Health Net Access, AHCCCS and RBHA or T/RBHA guidelines for referring their assigned members for behavioral health services. Referrals are based on, but not limited to:

- member request (members may also self-refer to a behavioral health provider)
- sentinel event, such as a member-defined crisis episode
- psychiatric hospitalization
- identification of behavioral health diagnosis outside the scope of the PCP or substance abuse issues

PCPs may refer members for the following services by contacting the Health Net Access Behavioral Health Unit (for dual-eligible members) or the RBHA or T/RBHA (for Medicaid-only members):

- behavioral health services
- consultation with a Health Net Access or T/RBHA behavioral health provider
- one-time, face-to-face psychiatric evaluation with the Health Net Access or RBHA or T/RBHA behavioral health provider for treatment, ongoing behavioral health care or medication management. To request this service, PCPs must complete and submit the behavioral health referral form and check one-time, face-to-face request

Additionally, PCPs are encouraged to call or refer members to the Maricopa Crisis Line, 24 hours, seven days a week, if the member experiences a behavioral health crisis, including danger to self or others.

If the member's behavioral health needs require behavioral health services outside the PCP's scope, the PCP is required to refer the member to Health Net Access (for dual-eligible members) or the RBHA or T/RBHA for assessment and referral to a behavioral health care provider.

For dual-eligible members, PCPs should contact Health Net Access using the behavioral health telephone number on the member's Health Net Access identification card for a referral to Health Net Access contracted behavioral health provider.

For non-dual-eligible members, PCPs may use the ADHS/DBHS Referral For Behavioral Health form located at www.healthnetaccess.com to make a referral. The PCP must ensure the member is transitioned to the RBHAor T/RBHA by:

- completing the member transfer notification
- providing information on the member's medication prescription and management
- ensuring medications are bridged until the member is transitioned

If a PCP determines the member needs an SMI eligibility determination, they should contact the Mercy Maricopa Member Services Line.

Problem Resolution

Found in: Operations Manuals > Benefits > Behavioral Health Effective 09/12/2016

The Health Net Access behavioral health coordinator initiates Health Net Access' problem resolution policy and procedure when problems arise concerning the provision of behavioral health treatment services, excluding member and provider grievance and appeals.

Psychotropic Prescription and Management

Found in: Operations Manuals > Benefits > Behavioral Health Effective 08/11/2016

Primary care physicians (PCPs) may treat and prescribe medication for the following behavioral health diagnoses:

- attention deficit hyperactivity disorder (ADHD)
- anxiety disorder
- mild depression
- postpartum depression

PCPs must transfer the member to a behavioral health provider contracting with Health Net Access (for dual-eligible members) or the Regional Behavioral Health Authority (RBHA) or Tribal/Regional Behavioral Health Authority (T/RBHA) if symptoms become severe or if the member needs additional behavioral health services. PCPs must ensure members are not simultaneously receiving behavioral health medication from both the behavioral health provider and PCP. When the member is identified to be simultaneously receiving medications from the PCP and behavioral health provider, the PCP must immediately contact the behavioral health provider to coordinate care and agree on who will continue to medically manage the person's behavioral health condition.

PCPs must use step therapy as needed for ADHD, anxiety disorder, mild depression, and postpartum depression. Step therapy is required for medication not on the Arizona Health Care Cost Containment System (AHCCCS) or Division of Behavioral Health Services (DBHS) preferred drug list. This includes the requirement that if the PCP receives documentation from Health Net Access, RBHA or T/RBHA behavioral health providers regarding completion of step therapy, the PCP continues prescribing the same brand and dosage of current medication unless a change in medical condition is clearly evident.

Psychotropic medications are listed in the *Health Net Access Drug List*, available on the provider website at www.healthnetaccess.com. For additional information regarding pharmacy benefits, contact Health Net Pharmaceutical Services.

Breast Reconstructive Surgery

Found in: Operations Manuals > Benefits Effective 07/01/2013

Breast Reconstructive Surgery after Mastectomy

Found in: Operations Manuals > Benefits > Breast Reconstructive Surgery Effective 09/12/2016

Health Net Access covers breast reconstruction surgery for eligible Health Net Access members following a medically necessary mastectomy regardless of the member's eligibility status at time of the mastectomy. Health Net Access does not cover services provided solely for cosmetic purposes.

A member may elect to have breast reconstruction surgery immediately following a mastectomy or may choose to delay breast reconstruction, but the member must be enrolled in Health Net Access at the time of breast reconstruction surgery. The type of breast reconstruction performed is determined by the physician in consultation with the member.

Breast reconstructive surgery coverage includes:

- Reconstruction of the affected and the unaffected contralateral breast. Reconstructive breast surgery of the unaffected contralateral breast following mastectomy is considered medically necessary only when required to achieve relative symmetry with the reconstructed affected breast. The surgeon must determine medical necessity and request prior authorization for reconstructive breast surgery of the unaffected contralateral breast prior to the time of reconstruction or during the immediate post-operative period
- Medically necessary implant removal and implant replacement when the original implant was the result of a medically necessary mastectomy. Implant replacements are not covered when the purpose of the original implant was cosmetic, such as augmentation
- External prostheses, including a surgical brassiere, for members who choose not to have breast reconstruction, or who choose to delay breast reconstruction until a later time

Prior authorization is required for breast reconstruction surgery. Coverage for prosthetic devices and reconstructive surgery is subject to copayment that is applicable to the mastectomy and all other terms and conditions applicable to other benefits.

Covered and Non-Covered Medical Services

Found in: Operations Manuals > Benefits Effective 05/18/2016

Covered Services

For covered medical benefits, detailed service descriptions, and exclusions and limitations, including behavioral health services, refer to the AHCCCS Medical Policy Manual (AMPM) as follows:

- www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf
- www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1200.pdf
- www.azdhs.gov/bhs/documents/covserv/covered-bhs-guide.pdf

Non-Covered Services

The following services are not covered for Health Net Access members:

- Services from a provider who is not contracting with Health Net Access (unless prior authorized).
- Cosmetic services or items unless medically necessary and prior authorized.
- Personal care items, such as combs, razors, soap, etc.
- Any service that requires prior authorization that was not prior authorized.
- Services or items given free of charge or for which charges are not usually applicable.
- Services of special duty nurses unless medically necessary and prior authorized.
- Routine circumcisions.
- Services that are determined to be experimental by the Health Net Access medical director/designee.
- Pregnancy terminations and pregnancy termination counseling unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother.
- Health services for incarcerated members.
- Experimental organ transplants unless approved by AHCCCS.
- Sex change operations.
- Reversal of voluntary sterilization.
- Medications and supplies without a prescription.
- Treatment to straighten teeth unless medically necessary and approved.
- Prescriptions not on the Health Net Access list of covered medications unless prior authorized.
- Diapers solely for personal hygiene.
- Physical exams for the purpose of qualifying for employment or sports activities.
- Children's Rehabilitative Services (CRS) for members enrolled in CRS or who have been accepted for the CRS program, but have declined to enroll.

Additional Non-Covered Services for Adults

The following services are also not covered for Health Net Access adult members (ages 21 and older):

- Hearing aids, including bone-anchored hearing aids.
- Cochlear implants.
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.
- Percussive vests.
- Services performed by a podiatrist (excluding dually eligible Health Net Medicare members*))
- Routine eye examinations for prescriptive lenses or glasses.
- Routine dental services and emergency dental services unless related to the treatment of a medical condition, such as acute pain, infection or fracture of the jaw.
- Chiropractic services (excluding dually eligible Health Net Medicare members*)
- Outpatient speech and occupational therapy (excluding dually eligible Health Net Medicare members*)

*Dually eligible Health Net Medicare members are those that are enrolled with Health Net for their Medicare benefit and Health Net Access for their Medicaid benefit. These members are eligible for their Medicare benefits under the Health Net Medicare program. Health Net Access is the secondary payer.

Dental Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Conscious Sedation Coverage

Found in: Operations Manuals > Benefits > Dental Services Effective 06/01/2016

Health Net Access covers conscious sedation for members receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Additional applications of conscious sedation for members receiving EPSDT services are considered on a case-by-case basis and require medical review and prior authorization by Health Net Access for enrolled members.

Dental Home

Found in: Operations Manuals > Benefits > Dental Services Effective 05/18/2016

The American Academy of Pediatric Dentistry (AAPD) defines the dental home as the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home must include:

- Comprehensive oral health care, including acute care and preventive services in accordance with the Arizona Health Care Cost Containment System (AHCCCS) Dental Periodicity Schedule.
- Comprehensive assessment for oral diseases and conditions.
- Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment.
- Anticipatory guidance about growth and development issues (such as teething, digit or pacifier habits).
- Plan for acute dental trauma.
- Information about proper care of the child's teeth and gingivae. This would include the prevention, diagnosis and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function and esthetics of those structures and tissues.
- Dietary counseling.
- Referrals to dental specialists when care cannot directly be provided within the dental home.

Members must be assigned to a dental home by age one and seen by a dentist for routine preventive care according to the AHCCCS Dental Periodicity Schedule. Members must also be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

Although the AHCCCS Dental Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to dentists who are in the Health Net Access provider network.

Dental Services for Members Ages 21 and Older

Found in: Operations Manuals > Benefits > Dental Services Effective 05/18/2016

Health Net Access covers medical and surgical services provided by a dentist only to the extent such services:

- May be performed under state law by either a physician or a dentist and,
- The services would be considered physician services if provided by a physician.

Health Net Access also covers limited dental services as a prerequisite to covered transplantation and when they are in preparation for radiation treatment for certain cancers.

Covered Services

Services provided by dentists are covered for members ages 21 and older, and must be related to the treatment of a medical condition, such as acute pain (excluding temporomandibular joint (TMJ) pain), infection or fracture of the jaw. Covered services include a limited problem-focused examination of the oral cavity, required radiographs, complex oral surgical procedures, such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

Exception for Transplant and Cancer Cases

For members who require medically necessary dental services as a prerequisite to covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations. For purposes of this policy a simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. Health Net Access covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered.

Exclusions and Limitations

Except for limited dental services covered for pre-transplant candidates and for members with cancer of the jaw, neck or head described above, covered services furnished by dentists to members ages 21 and older do not include services that physicians are not generally competent to perform, such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

Dental Services for Members Younger than Age 21

Found in: Operations Manuals > Benefits > Dental Services Effective 05/18/2016

Health Net Access dental providers must adhere to the Arizona Health Care Cost Containment System (AHCCCS) appointment standards listed in the table below:

Category	**AHCCCS Dental Appointment Standards**
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

EPSDT Covered Services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers the following dental services:

- Emergency dental services, including:
  - Treatment for pain, infection, swelling and/or injury.
  - Extraction of symptomatic (including pain), infected and nonrestorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic).
  - General anesthesia, conscious sedation or anxiolysis when local anesthesia is contraindicated or when management of the patient requires it. (Refer to Conscious Sedation Coverage section.).

- Preventive dental services provided as specified in the Arizona Health Care Cost Containment System (AHCCCS) Dental Periodicity Schedule, including, but not limited to:
  - Diagnostic services, including comprehensive and periodic examinations. Health Net Access allows two oral examinations and two oral prophylaxis and fluoride treatments per member per year (one every six months) for members ages 12 months through age 20 years.
  - Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth X-rays, supplemental bitewing X-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry (AAPD).
  - Panorex films are covered as recommended by AAPD, up to three times maximum per provider for children between ages 3 to 20. Additional panorex films needed above this limit must be deemed medically necessary through the Health Net Access prior authorization process. Preventive services, including:
    - Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian.
    - Application of topical fluorides. The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment.
    - Dental sealants for first and second molars are covered every three years up to age 15, with a two-time maximum benefit. Additional applications must be deemed medically necessary and require prior authorization through Health Net Access.

        - Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the Health Net Access PA process.

- All therapeutic dental services are covered when they are considered medically necessary and cost effective, but may be subject to prior authorization through Health Net Access. These services include, but are not limited to:
    - Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery.
    - Crowns:
        - When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or
        - Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are ages 18 through 20.

    - Endodontic services, including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar).
    - Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations, unless the member is age 18 through 20 and has had endodontic treatment.
    - Restorations of anterior teeth for children under age 5, when medically necessary. Children ages 5 and older with primary anterior tooth decay should be considered for extraction if presenting with pain or severely broken down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider.
    - Removable dental prosthetics, including complete dentures and removable partial dentures.
    - Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered for cosmetic purposes. Examples of conditions that may require orthodontic treatment include the following:
        - Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services,
        - Trauma requiring surgical treatment in addition to orthodontic services, or
        - Skeletal discrepancy involving maxillary and/or mandibular structures.

Services or items furnished solely for cosmetic purposes are excluded.

KidsCare Members Under Age 19

KidsCare services must be provided according to community standards and standards set forth for members enrolled for EPSDT services. Service descriptions and limitations for EPSDT also apply for the KidsCare program.

Informed Consent

Found in: Operations Manuals > Benefits > Dental Services Effective 05/18/2016

Informed consent is a process by which the dental provider advises the member or member's parent or legal guardian of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

- A written consent for examination and/or any preventive treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.
- A separate written consent for any irreversible, invasive procedure, including, but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member's parent or legal guardian receiving a copy of the complete treatment plan.

Providers must complete the appropriate informed consents and treatment plans for Health Net Access members as listed above, in order to provide quality and consistent

care, in a manner that protects and is easily understood by the member and/or the member's parent or legal guardian. Consents and treatment plans must be in writing and signed and dated by both the provider and the member or the member's parent or legal guardian, if the member is age 18 and under, or older and considered an incapacitated adult. Completed consents and treatment plans must be maintained in the member's chart and are subject to audit.

Dental Periodicity Schedule

Found in: Operations Manuals > Benefits > Dental Services Effective 05/11/2016

EXHIBIT 431-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*				
These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.				
AGE	**12-24 months**	**2-6 years**	**6-12 years**	**12 years and older**
Clinical oral examination including but not limited to the following:[1]	X	X	X	X
➢ Assess oral growth and development	X	X	X	X
➢ Caries-risk Assessment	X	X	X	X
➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

NOTE: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Dialysis

Found in: Operations Manuals > Benefits Effective 03/01/2012

Overview

Found in: Operations Manuals > Benefits > Dialysis Effective 09/12/2016

Health Net Access covers hemodialysis and peritoneal dialysis services provided by participating Medicare-certified hospitals or Medicare-certified end-stage renal disease (ESRD) providers. Hemoperfusion is covered when medically necessary. Services may be provided on an outpatient basis or on an inpatient basis if the hospital admission is not solely to provide chronic dialysis services. Hospital admissions solely to provide chronic dialysis are not covered.

Medically necessary outpatient dialysis treatments are covered, including:

- Supplies
- Diagnostic testing (including routine medically necessary laboratory tests)
- Medications

Inpatient dialysis treatments are covered when the hospitalization is for:

- Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)
- Medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program
- Placement, replacement or repair of the chronic dialysis route

Limitations

Out-of-state services are covered as provided for under Subpart B of 42 CFR 431. This includes services that, as determined on the basis of medical advice, are more readily available in other states, and services needed due to a medical emergency. Services furnished to Health Net Access members outside the United States are not covered.

Durable Medical Equipment

Found in: Operations Manuals > Benefits Effective 01/01/2003

Coverage

Found in: Operations Manuals > Benefits > Durable Medical Equipment Effective 05/18/2016

Durable medical equipment (DME) is paid for in accordance with the *Provider Participation Agreement* (*PPA*). Fee-for-service (FFS) providers may be directed to any participating Health Net Access DME provider, including Preferred Homecare.

Prosthetic and orthotic services are not available through Health Net Access' preferred DME provider (Preferred Homecare). They may be obtained through prosthetic and orthotic providers, such as Hanger Prosthetics and Orthotics.

Exclusions and Limitations

Health Net Access does not cover the following items:

- Personal care items, unless needed to treat a medical condition (except incontinence briefs and pads for members over age 3 and under age 21).
- First aid supplies (except under a prescription).
- Hearing aids for members ages 21 and older.
- Prescriptive lenses for members ages 21 and older (except if medically necessary following cataract removal).
- Penile implants or vacuum devices for members who are ages 21 and older.

Orthotics

Found in: Operations Manuals > Benefits > Durable Medical Equipment Effective 09/04/2015

Orthotics are rigid or semi-rigid devices affixed to the body externally and required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.

Custom Orthotics

A prior authorization is required for custom orthotics.

Coverage for Members Under Age 21

Orthotic devices are a covered benefit for Health Net Access members under age 21 when they are medically necessary and the orthotics cost less than other treatments that are as helpful for the condition.

Coverage for Members Ages 21 and Older

Orthotic devices are a covered benefit for Health Net Access members ages 21 and older when all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
- The member's primary care physician (PCP) or other physician orders the orthotic.

The following prosthetics are not covered for members ages 21 and older.

- bone-anchored hearing aids (BAHA), also known as osseointegrated implants
- cochlear implants
- insulin pumps
- percussive vests

Orthotic services are not available through Health Net's preferred DME provider (Preferred Homecare). They may be obtained through prosthetic and orthotic providers, such as Hanger Prosthetics and Orthotics.

Service Providers

Found in: Operations Manuals > Benefits > Durable Medical Equipment Effective 09/12/2016

Durable medical equipment (DME) is paid for in accordance with the Provider Participation Agreement (PPA). Fee-for-service (FFS) providers may be directed to any participating Health Net Access DME provider, including Preferred Homecare.

For insulin pumps and supplies, contact Animas Diabetes Care, LLC or MiniMed, Inc.

Members may obtain orthotics and prosthetics from any Health Net Access participating provider, such as Hanger Prosthetics and Orthotics.

Emergency Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Emergency Services

Found in: Operations Manuals > Benefits > Emergency Services Effective 05/16/2016

Health Net Access provides coverage for emergency services to all members. An emergency medical condition is defined as the treatment for a medical condition, including emergency labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency medical services are services provided for the treatment of an emergency medical condition and are:

- Furnished by a provider qualified to furnish emergency services.
- Needed to evaluate or treat an emergency medical condition.

Emergency services are covered both in-network and out-of-network and do not require prior authorization. In accordance with the Arizona Health Care Cost Containment Systems (AHCCCS) and 42 CFR 438.114, emergency room screening and stabilization services do not require prior authorization to be covered by Health Net.

If a member receives emergency care at an out-of-network hospital and needs inpatient care after the emergency condition is stabilized, he or she must receive inpatient care at the out-of-network hospital authorized by Health Net Access. The cost is the cost-sharing amount the member would pay at a network hospital.

For members who are hospitalized at an out-of-network hospital, Health Net Access and its delegates may offer to move the member, when the attending emergency physician or the treating physician determines the member is sufficiently stabilized for transfer or discharge, to an in-network hospital when ongoing inpatient care is indicated. Health Net Access recognizes the attending emergency physician or the treating physician makes the determination as to when the patient is stable for transfer.

In accordance with Senate bill (SB) 1034, Health Net Access is required to educate its members about the appropriate use of emergency services when a member inappropriately seeks care at a hospital emergency department four or more times in a six-month period. Health Net Access sends an emergency room educational letter to all identified members and their assigned primary care providers (PCPs). Members may also be enrolled in an emergency room diversion case management program to assist in coordinating care, educating members on appropriate use of the ER, and identifying

appropriate actions to take when care is needed. Case managers work with members' PCPs to address concerns.

Providers, including emergency departments, may refer members to the emergency room diversion program by calling the Case Management Department or by faxing a Case Management Referral form. Providers may contact the Provider Services Center for general questions.

Health Net Access expects members to schedule appointments during office hours whenever possible instead of using urgent care facilities or emergency rooms. Providers must follow appointment standards to meet members' urgent and emergent care needs.

Eye Examinations and Optometry Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Coverage Explanation

Found in: Operations Manuals > Benefits > Eye Examinations and Optometry Services
Effective 07/01/2013

Health Net Access covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility:

- Emergency eye care, which meets the definition of an emergency medical condition
- For members age 21 and older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses
- Vision examinations and the provision of prescriptive lenses for members under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT), KidsCare program and for adults when medically necessary following cataract removal
- Cataract removal for all eligible members under certain conditions. Details of coverage criteria are available on the Arizona Health Care Cost Containment System (AHCCCS) website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf

Coverage Specifications for Children (Under age 21)

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye are covered
- Primary care physicians (PCPs) are required to provide initial vision screening in their office as part of the EPSDT program
- Members under age 21 with vision screening of 20/60 or greater should be referred to the contracting vision provider for further examination and possible provision of glasses
- Replacement of lost or broken eyeglasses is covered
- Contact lenses are not covered

Coverage Specifications for Adults (Age 21 and older)

- Emergency care for eye conditions that meet the definition of an emergency medical condition is covered
- Cataract removal and/or medically necessary vision examinations, including prescriptive lenses if needed following cataract removal, is covered
- Routine eye exams and glasses are not covered

Family Planning

Found in: Operations Manuals > Benefits Effective 07/01/2013

Provider Responsibility

Found in: Operations Manuals > Benefits > Family Planning Effective 05/23/2016

Health Net Access members may obtain family planning services and supplies from any qualified family planning provider without referral or prior authorization. Family planning services are covered for members who voluntarily choose to delay or prevent pregnancy.

All providers are responsible for:

- Making appropriate referrals to health professionals who provide family planning services.

- Keeping complete medical records regarding referrals.
- Verifying and documenting a member's willingness to receive family planning services.
- Providing medically necessary management of members with family planning complications.
- Notifying members of available contraceptive services and making these services available to all members of reproductive age using the following guidelines:
    - Information for members who are ages 17 and younger must be given to the member's parent or guardian.
    - Information for members between ages 18 to 55 must be provided directly to the member or legal guardian.
    - Whenever possible, contraceptive services should be offered in a broad-spectrum counseling context, which includes discussion of mental health and sexually transmitted diseases, including AIDS.
    - Members of any age whose sexual behavior exposes them to possible conception or sexually transmitted infections (STIs) should have access to the most effective methods of contraception.
    - Every effort should be made to include male or female partners in such services.

Member Education

In order for members to make informed decisions, counseling should provide accurate, up-to-date information regarding available family planning methods and prevention of sexually transmitted diseases.

Health Net Access providers are responsible for:

- Providing counseling and education to members of both genders that is age appropriate and includes information on prevention of unplanned pregnancies.
- Counseling for unwanted pregnancies. Counseling should include the member's short- and long-term goals.
- Spacing of births to promote better outcomes for future pregnancies.
- Preconception counseling to assist members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
- Discussion of sexually transmitted diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.
- Contraceptives should be recommended and prescribed for sexually active members.

Providers are required to discuss the availability of family planning services annually. If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted diseases (including AIDS). Documentation must be recorded in the member's medical record that each member of reproductive age was notified verbally or in writing of the availability of family planning.

Such discussions must be:

- Provided in a manner free from coercion or behavioral/mental pressure.
- Available and easily accessible to members.
- Provided in a manner that assures continuity and confidentiality.
- Provided by, or under the direction of, a qualified provider.
- Documented in the medical record.

Sterilization

Found in: Operations Manuals > Benefits > Family Planning Effective 05/23/2016

Sterilization services, including hysteroscopic tubal sterilizations, are covered for both male and female members who meet the requirements specified in the Health Net Access policy for sterilization services.

The following requirements must be met for sterilization services to be covered:

- The member is at least age 21 at the time he or she signs the consent form.
- Mental competency is determined.
- Voluntary consent was obtained without coercion.
- 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the

informed consent must have been given at least 30 days before the expected date of delivery.

Members requesting sterilization must sign an appropriate consent form with a witness present. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to members with limited-English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations. Prior to signing the consent form, a member must be offered factual information, including:

- Consent form requirements.
- Answers to questions asked regarding the specific procedure to be performed.
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits.
- A description of available alternative methods.
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the advantages or disadvantages that may be expected as a result of the sterilization.
- Notification that sterilization cannot be performed for at least 30 days post-consent.

Sterilization consents may not be obtained when a member is:

- In labor or childbirth.
- Seeking to obtain, or is obtaining, pregnancy termination.
- Under the influence of alcohol or other substances that affect that member's state of awareness.

Foot and Ankle

Found in: Operations Manuals > Benefits Effective 07/01/2013

Foot and Ankle Services

Found in: Operations Manuals > Benefits > Foot and Ankle Effective 07/01/2013

Health Net Access covers medically necessary foot and ankle care services, including the following, when ordered by a member's primary care physician (PCP), attending physician or practitioner within certain limits for eligible Health Net Access members.

- Under age 21 - Bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a non-professional person
- Age 21 or older - Wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services. Medically necessary routine foot care services are only available for members with a severe systemic disease that prohibits care by a nonprofessional. Services are not covered when provided by a podiatrist or podiatric surgeon. Members can be referred to other contracting providers who can perform medically necessary foot and ankle procedures, including reconstructive surgeries. A prescription written by a podiatrist would not automatically disqualify the prescribed medication (device or service) from payment. However, the prescribed medication, device or service may be subject to prior authorization to determine whether it is covered

Bunionectomies are covered only when the bunion is present with:

- Overlying skin ulceration
- Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report)

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Routine Foot Care

Routine foot care is defined as services performed in the absence of localized illness, injury or symptoms involving the foot. Routine foot care is considered medically necessary in very limited circumstances. These services include:

- Cutting or removal of corns or calluses
- Nail trimming (including mycotic nails)
- Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the feet, and the use of skin creams to maintain skin tone of both ambulatory and bedfast patients)

Routine foot care is considered medically necessary when the member has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional would be hazardous. Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include, but are not limited to:

- Anticoagulation therapy in progress
- Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis
- Diabetes mellitus
- Peripheral neuropathies involving the feet
- Chemotherapy in progress
- Pernicious anemia
- Hereditary disorder, such as hereditary sensory radicular neuropathy or Fabry's disease
- Hansen's disease or neurosyphilis
- Malabsorption syndrome

- Multiple sclerosis
- Traumatic injury
- Uremia (chronic renal disease)

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered when the member has all of the following:

- A systemic condition
- Clinical evidence of mycosis of the toenail
- Compelling medical evidence documenting the member either:
    - Has a marked limitation of ambulation due to the mycosis, which requires active treatment of the foot
    - In the case of a nonambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Limitations

Coverage is limited as follows:

- Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) members)
- Coverage of mycotic nail treatments does not exceed one bilateral mycotic nail treatment (up to 10 nails) per 60 days (this does not apply to EPSDT members)
- Neither general diagnoses, such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency, or incapacitating injuries or illnesses, such as rheumatoid arthritis, CVA (stroke) or fractured hip, are diagnoses under which routine foot care is covered.

Health Risk Assessments and Screening Tests

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Health Risk Assessments and Screening Tests
Effective 07/01/2013

Health Net Access covers health risk assessment and screening tests provided by a physician, primary care provider (PCP) or other licensed practitioner within the scope of his or her practice under state law for all members. These services include appropriate clinical health risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status.

Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) and KidsCare

Program.

Covered Services

Found in: Operations Manuals > Benefits > Health Risk Assessments and Screening Tests
Effective 07/01/2013

Preventive health risk assessment and screening test services for non-hospitalized adults include, but are not limited to:

- Hypertension screening (annually)
- Cholesterol screening (once; additional tests based on history)
- Routine mammography annually after age 40 and at any age if considered medically necessary
- Cervical cytology, including Pap smears (annually for sexually active women; after three successive normal exams, the test may be less frequent)
- Colon cancer screening (digital rectal exam and stool blood test, annually after age 50, as well as baseline colonoscopy after age 50)
- Sexually transmitted disease screenings (at least once during pregnancy; other based on history)
- Tuberculosis screening (once, with additional testing based on history; for members residing in a facility, as necessary, per health care institution licensing requirement)
- HIV screening
- Immunizations
- Prostate screening (annually after age 50; screening is recommended annually for males ages 40 and older who are at high risk due to immediate family history)
- Physical examinations, periodic health examinations or assessments, diagnostic workups or health protection packages designed to:
    - Provide early detection of disease
    - Detect the presence of injury or disease
    - Establish a treatment plan
    - Evaluate the results or progress of the treatment plan or disease
    - Establish the presence and characteristics of a physical disability which may be the result of disease or injury

Screening services provided more frequently than these professionally recommended guidelines are not covered unless medically necessary.

Services Not Covered

Found in: Operations Manuals > Benefits > Health Risk Assessments and Screening Tests
Effective 07/01/2013

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies, such as the following, are not covered services:

- Qualification for insurance
- Pre-employment physical examination
- Qualifications for sports or physical exercise activities
- Pilots examinations (Federal Aviation Administration)
- Disability certification for the purpose of establishing any kind of periodic payments
- Evaluation for establishing third party liability
- Preventive examinations in the absence of any know disease or symptom for members ages 21 and older

Home Health Services

Found in: Operations Manuals > Benefits Effective 01/01/2003

Overview

Found in: Operations Manuals > Benefits > Home Health Services Effective 07/01/2013

Home health services are provided on a part-time or intermittent basis to prevent hospitalization or institutionalization. Home health services must be obtained through a participating provider. Providers are required to utilize the preferred provider network for the member's benefit plan. Providers who are unsure of the preferred provider network should contact the Health Net Access Provider Services Center.

Home health services include medically necessary services provided in the member's place of residence, including:

- Home health nursing visits
- Home health aid services
- Medically necessary supplies
- Therapy services

Home health services require prior authorization. Refer to the Prior Authorization Requirements for Health Net Access for additional information.

Hospice Care

Found in: Operations Manuals > Benefits Effective 03/01/2012

Face-to-Face Encounters for Continued Hospice Eligibility

Found in: Operations Manuals > Benefits > Hospice Care Effective 02/02/2015

Hospice physicians or hospice nurse practitioners (NPs) must have a face-to-face encounter with every hospice patient to determine continued hospice eligibility. To satisfy this requirement, the following criteria must be met:

1. The face-to-face encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter.
2. The hospice physician or NP who conducts the face-to-face encounter must attest in writing to it. The attestation must be on a separate and distinct section of, or addendum to, the recertification form, be clearly titled and include the rendering physician's or NP's signature and date of face-to-face encounter. When an NP conducts the face-to-face encounter, the attestation must state the clinical findings were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, if the illness runs its normal course.

In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period (as described in criteria 1). For example, if the patient is an emergency admission on a weekend, it may be impossible for a hospice physician or NP to see the patient until the following Monday, or the hospice may be unaware that the member is in the third benefit period. In such documented cases, a face-to-face encounter within two days after admission is considered timely. If the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as completed.

The hospice must retain the certification statements and have them available for Health Net's audit purposes.

Hospice Care

Found in: Operations Manuals > Benefits > Hospice Care Effective 09/12/2016

Hospice services are covered when Health Net Access members have met hospice care requirements and the services are authorized by Health Net Access or a participating provider. The member's treating physician must certify the member as terminally ill and expected to live six months or less. The hospice and its employees must be Medicare-certified and licensed by the Arizona Department of Health Services (ADHS).

The following services are covered under hospice when provided in an approved setting:

- Bereavement services
- Continuous home care
- Dietitian services
- Home health aid services
- Homemaker services
- Nursing services provided by or under the supervision of a registered nurse
- Pastoral services
- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family or other persons caring for the member. Not to exceed more than 5 consecutive days at a time and not provided when the member is a nursing facility resident or receiving services in an inpatient setting
- Routine home care
- Medical social service consultations by a qualified social worker
- Therapy, including physical, occupational, respiratory, speech, music, and recreational
- 24-hour on-call availability to provide services such as reassurance, information and referral for members, family and caretakers
- Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee

- Medical and surgical supplies and durable medical equipment, including medications

Hospital and Skilled Nursing Facility

Found in: Operations Manuals > Benefits Effective 03/01/2012

Hospital and Skilled Nursing Facility Inpatient Services

Found in: Operations Manuals > Benefits > Hospital and Skilled Nursing Facility
Effective 05/16/2016

Health Net Access covers medically necessary inpatient hospital and skilled nursing facility (SNF) services provided by participating hospitals and SNFs for Health Net Access members.

Hospital services include accommodation, appropriate staffing, supplies, equipment, and services for the following:

- Routine acute medical care.
- Intensive and coronary care.
- Neonatal intensive care.
- Maternity care, including labor, delivery and recovery rooms, birth centers, and nursery and related services.
- Surgical care, including recovery rooms and anesthesiology services.
- Obstetrics and newborn nurseries.
- Behavioral health emergencies.
- Nursing services.
- Dietary services.
- Ancillary services, including:
  - chemotherapy
  - dialysis
  - laboratory
  - radiology
  - medications
  - medical supplies
  - respiratory therapy
  - rehabilitation services (PT, OT, speech therapy)
  - blood and blood derivatives
  - dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program

Health Net Access covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

Health Net Access covers up to 90 days of care in a SNF per contract year (generally October 1 through September 30) for members who are not eligible for Arizona Long-Term Care System (ALTCS) services. Services that are not covered separately when provided in a SNF include:

- Nursing services, such as administering medication, tube feedings, personal care services, routine testing of vital signs and blood glucose monitoring, assistance with eating and/or maintenance of catheters.
- Basic patient care equipment and supplies.
- Dietary services, including special diets and adaptive tools for eating.
- Physician visits made for meeting state requirements.
- Non-customized durable equipment and supplies.
- Rehabilitation therapies ordered as a maintenance regimen.
- Over-the-counter medications and laxatives.
- Social activity, recreational and spiritual services.
- Any other services, supplies or equipment that are state or county regulatory requirements or are included in the SNF's room and board rate.

An admission to a SNF must be prior authorized by the Health Net Medical Management Department before a member is admitted.

When Member Disenrolls While Hospitalized

Health Net Access notifies the hospital when a member disenrolls from Health Net Access while hospitalized. The hospital must contact the member's new health plan for authorization of continued services and discharge planning. Health Net Access concurrent review nurses work closely with the hospital to ensure that care is coordinated during the member's transition.

Upon completion of the member's initial consultation with a genetics physician and metabolic nutritionist, and the determination of metabolic formula and/or low-protein foods necessary to meet the member's nutritional needs, the provider forwards the request for metabolic nutrition to the medical foods liaison at AHCCCS/Office of Medical Policy and Programs (OMP) for review and processing. All approvals and payments for medical foods are the responsibility of AHCCCS administration.

Hospitalists

Found in: Operations Manuals > Benefits Effective 01/01/2003

Overview

Found in: Operations Manuals > Benefits > Hospitalists Effective 06/01/2011

Health Net contracts with several hospitalist service providers. Primary care physicians (PCPs) and specialists may admit their patients who are Health Net members, otherwise participating hospitalists must be used whenever hospitalist services are required. For assistance locating a participating hospitalist, contact the admitting facility directly or the Health Net Provider Network Management Department during normal business hours.

Continuity of Care

Found in: Operations Manuals > Benefits > Hospitalists Effective 06/01/2011

Hospitalists are required to provide the following member discharge information to the member's primary care physician (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 Health Net Discharge Summary Form or incorporate the information noted above into the form currently used.

Hysterectomy

Found in: Operations Manuals > Benefits Effective 07/01/2013

Special Considerations for Hysterectomy

Found in: Operations Manuals > Benefits > Hysterectomy Effective 07/01/2013

Health Net Access covers medically necessary hysterectomy services in accordance with federal regulations (42 CFR 441.250). Federal regulation 42 CFR 441.251 defines hysterectomy as a medical procedure or operation for the purpose of removing the uterus. Sterilization is defined by this regulation as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

Health Net Access does not cover hysterectomies when they are performed solely to render the individual permanently incapable of reproducing.

Hysterectomy services coverage is limited to cases in which medical necessity has been established and, prior to hysterectomy, there was a trial of medical or surgical therapy that was not effective in treating the member's condition.

Hysterectomy may be indicated for the following reasons, which include, but are not limited to:

- Dysfunctional uterine bleeding or benign fibroids associated with dysfunctional bleeding. A hysterectomy may be considered for members for whom medical and surgical therapy has failed, and childbearing is no longer a consideration
- Endometriosis. A hysterectomy is indicated for members with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy
- Uterine prolapse. A hysterectomy may be indicated in women with uterine prolapse for whom childbearing is no longer a consideration and for whom nonoperative and/or surgical correction, such as suspension or repair, will not provide the member adequate relief

Conditions Not Subject to Prior Therapy Trial

Hysterectomy services may be considered medically necessary without prior trial of therapy in the following cases:

- Invasive carcinoma of the cervix
- Ovarian carcinoma
- Endometrial carcinoma
- Carcinoma of the fallopian tube
- Malignant gestational trophoblastic disease
- Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
- Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy or placenta abruption

Prior Acknowledgement and Documentation

Prior to performing a hysterectomy, providers are required to:

- Inform the member and her representative, if applicable, both orally and in writing that the hysterectomy will render the member incapable of reproducing.
- Obtain from the member or representative, if applicable, a signed, dated written acknowledgment stating that the information above has been received and that the individual has been informed and understands the consequences of having a hysterectomy (result in sterility). This documentation must be kept in the member's medical record. A copy must also be kept in the member's medical record maintained by the member's Health Net Access primary care provider.

Participating providers must ensure members sign a consent form and may use the Arizona Health Care Cost Containment System (AHCCCS) Hysterectomy Consent form or other similar forms, as long as prior acknowledgement information is provided.

Exceptions from Prior Acknowledgement

Prior acknowledgment is not required in either of the following situations:

- The member was already sterile before the hysterectomy. The physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility
- The member requires a hysterectomy due to a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible. The physician must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible

Immunizations

Found in: Operations Manuals > Benefits Effective 01/01/2003

Coverage Explanation

Found in: Operations Manuals > Benefits > Immunizations Effective 03/03/2010

Medically necessary immunizations, as determined by Health Net, are covered under all Health Net plans and include adult immunizations recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), and childhood and adolescent immunizations recommended by the ACIP, the American Academy of Pediatrics (AAP) or the American Academy of Family Physicians (AAFP). Most immunizations do not require a copayment.

Flu Shots

Found in: Operations Manuals > Benefits > Immunizations Effective 06/01/2009

Flu shots are available to all members. Copayments may only be collected for flu shots when given in conjunction with an office visit.

Immunization Administration

Found in: Operations Manuals > Benefits > Immunizations Effective 05/18/2016

Primary care providers (PCPs) are responsible for immunizing members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize Health Net Access members.

PCPs must be available to administer immunizations during routine office hours. It is the PCP's responsibility to update the immunization record card or other form of immunization record, and enter all immunizations into the Arizona State Immunization Information System (ASIIS) registry.

At each visit, the PCP should inquire whether the patient has received immunizations from another provider. The PCP should also educate members regarding their responsibility to inform the PCP if they receive immunizations elsewhere (such as from an LHD or nonparticipating provider). This information is necessary for documentation and for the member's safety.

EPSDT Program

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish and maintain up-to-date immunization status for each member based on his or her age. Refer to the CDC website at www.cdc.gov/vaccines/schedules/index.html for current immunization schedules.

For adult immunization coverage, refer to Chapter 300 Medical Policy for AHCCCS Covered Services, Policy 310-M, or to the CDC website at www.cdc.gov/vaccines/schedules/index.html for adult immunization recommendations.

Vaccines for Children Program

The federal Vaccines for Children (VFC) program is available to physicians who provide immunizations to Medicaid- eligible members. Providers are required to enroll in the program in order to participate. This federally funded program furnishes free vaccines in bulk to enrolled providers. All Medicaid-eligible children under age 19 may receive VFC vaccines.

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, not to exceed the maximum allowable set by the Centers for Medicare and Medicaid Services (CMS). Refer to the VFC Program Billing Procedures discussion for more information on reimbursement.

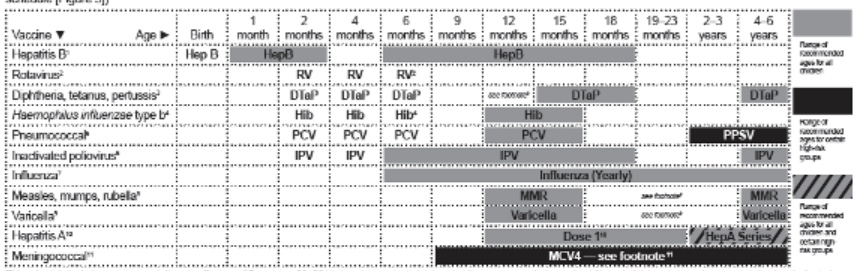
Participating providers must register with Arizona Department of Health Services (ADHS) as a vaccine provider. Providers must enroll in the VFC program and re-enroll annually.

EPSDT Program - AHCCCS Recommended Childhood and Adolescent Immunization Schedules

EXHIBIT 430-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RECOMMENDED CHILDHOOD AND ADOLESCENT
IMMUNIZATION SCHEDULES

FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])



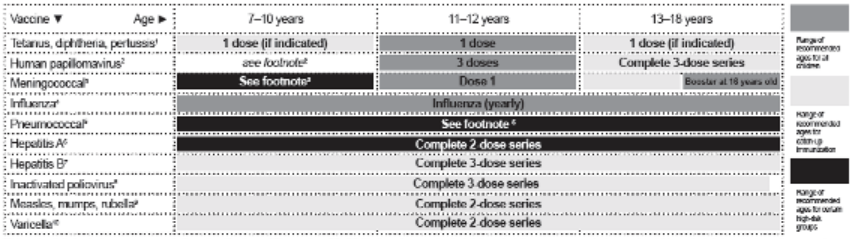
This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Hepatitis B (HepB) vaccine.** (Minimum age: birth)
   At birth:
   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after receiving the last dose of the series.
   - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

   Doses after the birth dose:
   - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
   - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
   - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
   - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.
2. **Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
4. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.
5. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
     — All children aged 14 through 59 months
     — Children aged 60 through 71 months with underlying medical conditions.
   - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010;59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
6. **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.
7. **Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - For children aged 6 months through 8 years:
     — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
8. **Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
9. **Varicella (VAR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
10. **Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
    - Administer the second (final) dose 6 to 18 months after the first.
    - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
    - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.
11. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])
    - For children aged 9 through 23 months 1) with persistent complement component deficiency, 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
    - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
    - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV cases.
    - See *MMWR* 2011;60:72–6, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003. pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www. cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, and *MMWR* 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/wk/mm6040. pdf, for further guidance, including revaccination guidelines.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).
Department of Health and Human Services • Centers for Disease Control and Prevention

FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])



This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
   - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
   - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.
2. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
   - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
   - The vaccine series can be started beginning at age 9 years.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
   - See *MMWR* 2010;59:626–32, available at http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf.
3. **Meningococcal conjugate vaccines, quadrivalent (MCV4).**
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
   - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
   - If the first dose is administered at age 16 years or older, a booster dose is not needed.
   - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
   - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
   - See *MMWR* 2011;60:72–76, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, for further guidelines.
4. **Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
   - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No.RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - Administer 1 dose to persons aged 9 years and older.
   - For children aged 6 months through 8 years:
     — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
5. **Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
   - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010;59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
   - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
6. **Hepatitis A (HepA) vaccine.**
   - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
   - Administer 2 doses at least 6 months apart to unvaccinated persons.
7. **Hepatitis B (HepB) vaccine.**
   - Administer the 3-dose series to those not previously vaccinated.
   - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
   - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered at least 6 months after the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
   - IPV is not routinely recommended for U.S. residents aged18 years or older.
9. **Measles, mumps, and rubella (MMR) vaccine.**
   - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
10. **Varicella (VAR) vaccine.**
    - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).
Department of Health and Human Services • Centers for Disease Control and Prevention

FIGURE 3. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States • 2012

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Persons aged 4 months through 6 years					
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus[1]	6 weeks	4 weeks	4 weeks[1]		
Diphtheria, tetanus, pertussis[2]	6 weeks	4 weeks	4 weeks	6 months	6 months[2]
Haemophilus influenzae type b[3]	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks[3] if current age is younger than 12 months 8 weeks (as final dose)[3] if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[4]	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks	6 months[5] minimum age 4 years for final dose	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months			
Hepatitis A	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria[9] tetanus, diphtheria, pertussis[9]	7 years[9]	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus[10]	9 years	Routine dosing intervals are recommended[10]			
Hepatitis A	12 months	6 months			
Hepatitis B	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks[5]	6 months[5]	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. **Rotavirus (RV) vaccines [RV-1 [Rotarix] and RV-5 [Rota Teq]].**
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 was administered for the first and second doses, a third dose is not indicated.
2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.**
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
3. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.**
   - Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
4. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously; or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.
   - Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See *MMWR* 2010;59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
5. **Inactivated poliovirus vaccine (IPV).**
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
6. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])
   - See Figure 1 ("Recommended immunization schedule for persons aged 0 through 6 years") and Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years") for further guidance.
7. **Measles, mumps, and rubella (MMR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years.
8. **Varicella (VAR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
9. **Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.**
   - For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
   - An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.
10. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).**
    - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
    - Use recommended routine dosing intervals for vaccine series catch-up, see Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years").

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines) or by telephone (800-CDC-INFO [800-232-4636]).

Immunization - Recommended Adult Schedule

Recommended Adult Immunization Schedule
United States - 2016

The 2016 Adult Immunization Schedule was approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Nurse-Midwives (ACNM). On February 2, 2016, the adult immunization schedule and a summary of changes from 2015 were published in the *Annals of Internal Medicine*, and the availability of the schedule was announced in the *Morbidity and Mortality Weekly Report (MMWR)* on February 4, 2016.

All clinically significant postvaccination reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

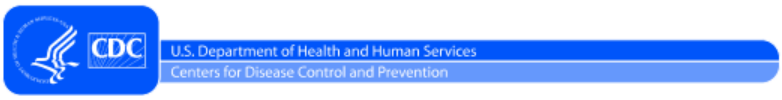
Additional details regarding ACIP recommendations for each of the vaccines listed in the schedule can be found at www.cdc.gov/vaccines/hcp/acip-recs/index.html.

American Academy of Family Physicians (AAFP)
www.aafp.org/

American College of Physicians (ACP)
www.acponline.org/

American College of Obstetricians and Gynecologists (ACOG)
www.acog.org/

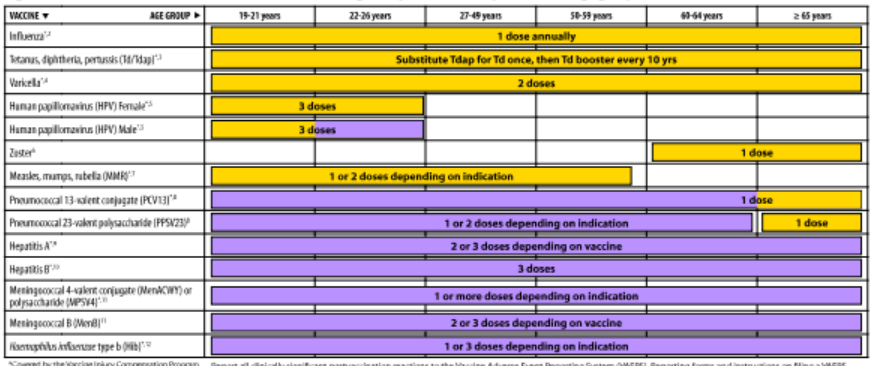
American College of Nurse-Midwives (ACNM)
www.midwife.org/



Recommended Adult Immunization Schedule—United States - 2016

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended immunization schedule for adults aged 19 years or older, by vaccine and age group[1]



*Covered by the Vaccine Injury Compensation Program

Recommended for all persons who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection; zoster vaccine is recommended regardless of past episode of zoster

Recommended for persons with a risk factor (medical, occupational, lifestyle, or other indication)

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

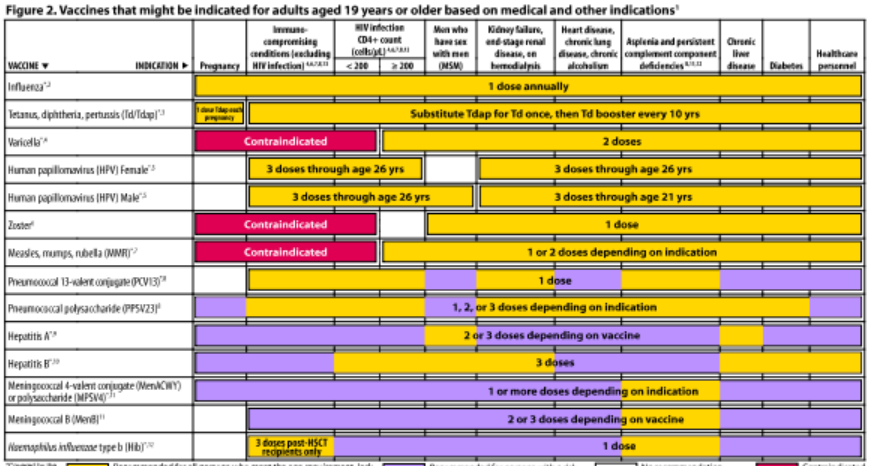
Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the America College of Physicians (ACP), the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM).

Figure 2. Vaccines that might be indicated for adults aged 19 years or older based on medical and other indications[1]



*Covered by the Vaccine Injury Compensation Program

Recommended for all persons who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection; zoster vaccine is recommended regardless of past episode of zoster

Recommended for persons with a risk factor (medical, occupational, lifestyle, or other indication)

No recommendation

Contraindicated

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly recommended for adults aged ≥ 19 years, as of February 2016. For all vaccines being recommended on the Adult Immunization Schedule, a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/hcp/acip-recs/index.html). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

1. Additional information

- have not received PCV13 but have received 2 doses of PPSV23: administer PCV13 at least 1 year after the most recent dose of PPSV23.
- have received PCV13 but not PPSV23: administer PPSV23 at least 8 weeks after PCV13. Administer a second dose of PPSV23 at least 5 years after the first dose of PPSV23.
- have received PCV13 and 1 dose of PPSV23: administer a second dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the first dose of PPSV23.
- If the most recent dose of PPSV23 was administered at age <65 years, at age ≥65 years, administer a dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the last dose of PPSV23.
- Immunocompromising conditions that are indications for pneumococcal vaccination are: congenital or acquired immunodeficiency (including B- or T-lymphocyte deficiency, complement deficiencies, and phagocytic disorders excluding chronic granulomatous disease), HIV infection, chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, multiple myeloma, solid organ transplant, and iatrogenic immunosuppression (including long-term systemic corticosteroids and radiation therapy).
- Anatomical or functional asplenia that are indications for pneumococcal vaccination are: sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, and splenectomy. Administer pneumococcal vaccines at least 2 weeks before immunosuppressive therapy or an elective splenectomy, and as soon as possible to adults who are newly diagnosed with asymptomatic or symptomatic HIV infection.

TABLE. Contraindications and precautions to commonly used vaccines in adults [1†]

Vaccine	Contraindications	Precautions
Influenza, inactivated (IIV)[2]		

Immunization - Recommended Childhood and Adolescent Schedule

Recommended Immunization Schedules for Persons Aged 0 Through 18 Year
UNITED STATES, 2016

This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statemer for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinical significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

The Recommended Immunization Schedules for
Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(http://www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(http://www.aap.org)

American Academy of Family Physicians
(http://www.aafp.org)

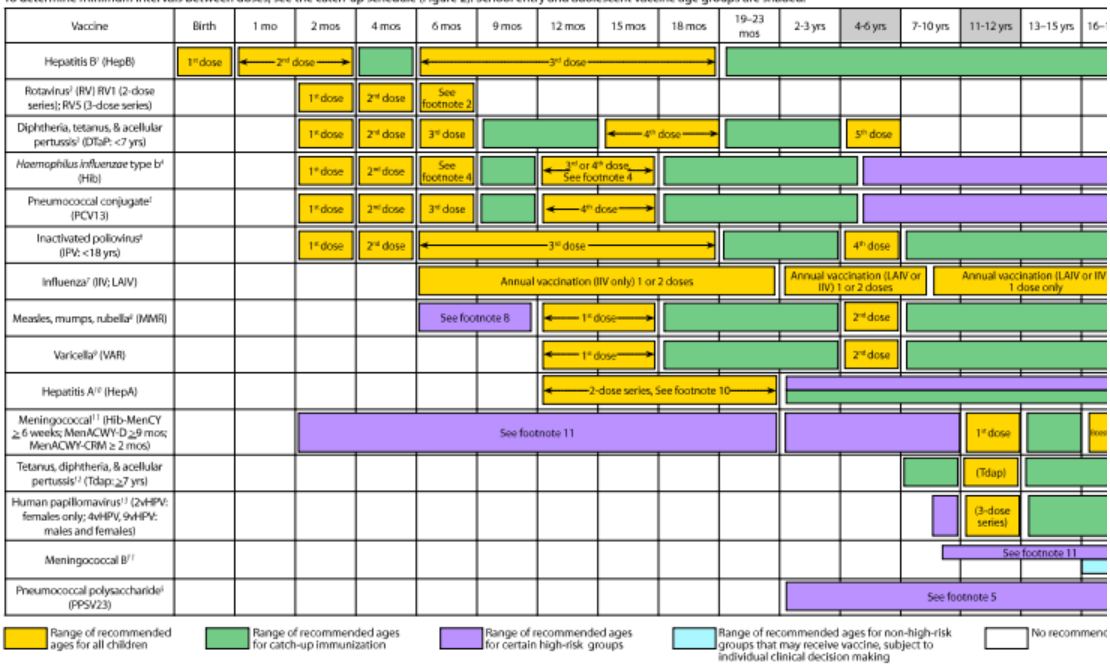
American College of Obstetricians and Gynecologists
(http://www.acog.org)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2016.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figu
To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.



This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Acade Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind — United States, 2016.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Children age 4 months through 6 years

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to D
Hepatitis B[1]	Birth	4 weeks	8 weeks and at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks	4 weeks	4 weeks[2]		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 month
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed If first dose was administered at age 15 months or older.	4 weeks[4] If current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown. 8 weeks and age 12 through 59 months (as final dose for healthy children)[4] — —		

Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.
Additional information

4. ***Haemophilus influenzae*** type b (Hib) conjugate vaccine (cont'd)

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

10. Hepatitis A (HepA) vaccine (cont'd)
Special populations:

Injectables

Found in: Operations Manuals > Benefits Effective 01/01/2003

Injectable Medications

Found in: Operations Manuals > Benefits > Injectables Effective 07/26/2013

Participating providers must obtain any injectable medications they administer. Members cannot obtain these medications through there outpatient prescription medication benefits.

Refer to the member's *Evidence of Coverage* (*EOC*) and *Summary of Benefits* for complete injectable medication benefit coverage information. Particpating providers can also go to provider.healthnet.com > Pharmacy Information for medication information.

Prior Authorization

Found in: Operations Manuals > Benefits > Injectables Effective 07/01/2013

Health Net covers medically necessary injectable medications administered by a Health Net participating providers in an office setting. Most injectable medications administered in the office do not require prior authorization; however, prior authorization is required for the medications listed on the in-office Injectable Drugs Requiring Prior Authorization/Precertification list. This is not intended to be an all-inclusive list and is subject to change as new brand-name equivalents become available. All self-injectable medications other than preferred insulin vials require prior authorization. Prior authorization is also required for growth hormones prescribed for home use.

Prior Authorization Procedures

Found in: Operations Manuals > Benefits > Injectables Effective 07/01/2013

To obtain prior authorization from Health Net Pharmaceutical Services (HNPS) for in-office- administered injectable medications, self-injectable medications and non-preferred medications:

1. Complete a Health Net Prior Authorization/Formulary Exception Request Fax Form.
2. Fax the form to Health Net Pharmaceutical Services.

Most requests receive a response via fax within two business days.

Self-Injectable Medications

Found in: Operations Manuals > Benefits > Injectables Effective 07/26/2013

Most self-injectable medications, other than preferred insulins, require prior authorization. Refer to the Injectable Drugs Requiring Prior Authorization/Precertification list for more information. This is not intended to be an all-inclusive list and is subject to change as new injectables become available. For more information on medication prior authorization, refer to the Health Net website at provider.healthnet.com > *Pharmacy Information.*

Members must obtain self-injectable medications at retail pharmacies through the members' outpatient pharmacy benefits and cannot obtain self-injectables from a participating provider's office. Some self-injectable medications must be obtained from Health Net's preferred specialty pharmacies (as indicated in the prior authorization approval).

On rare occasions, self-injectable medications may require administration by a health care professional and prior authorization is required.

Maternity

Found in: Operations Manuals > Benefits Effective 01/01/2003

Healthy Pregnancy Program

Found in: Operations Manuals > Benefits > Maternity Effective 08/19/2013

The Decision Power® *Healthy Pregnancy* program educates women and provides screening to identify high-risk pregnancies. This program has been effective in prolonging pregnancies, improving birth weights and minimizing hospitalizations, by featuring the following:

- Initial assessment and risk screening, conducted at time of enrollment
- Online educational resources
- The book, *Your Journey Through Pregnancy*, which includes information from early pregnancy through the baby's first weeks, and a resource bookmark

- Access to BabyLine® - a telephone line answered by highly experienced nurses, 24 hours a day, seven days a week, for questions related to pregnancy
- Second assessment at approximately 28 weeks
- Referrals to case management for those at-risk participants identified during assessments
- Final assessment completed post-delivery
- Assessment report for participants and their physicians

Pregnant members identified as high risk and enrolled in the high-risk obstetric case management program have access to the expertise and experience of high-risk obstetric nurse case managers who are available to program participants 24 hours a day, seven days a week. The case manager creates a care plan unique for each participant, by helping to set goals and develop strategies to assist the participant. Case managers also coordinate home-care and neonatal intensive care unit (NICU) care as needed. Refer eligible Health Net expectant mothers to this program via fax.

Maternity Care Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Maternity Care Services Effective 10/29/2015

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 and must be provided in compliance with the most current American Congress of Obstetricians and Gynecologists (ACOG) standards for obstetric and gynecologic services. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Prenatal care, labor and delivery, and postpartum care services may be provided by licensed midwives within their scope of practice.

Pregnant members have the option to select a primary care physician (PCP) who provides obstetrical care. Members who receive maternity services from a certified nurse midwife or a licensed midwife are also assigned to a PCP for other health care and medical services.

To ensure continuity of care, members who transition to or enrolled with another health plan during their third trimester may continue to receive maternity care from their current AHCCCS-registered provider.

High-Risk Maternity Care

Found in: Operations Manuals > Benefits > Maternity Care Services Effective 05/23/2016

In partnership with obstetric providers, Health Net Access' Medical Management Department identifies pregnant women who are at risk for adverse pregnancy outcomes.

Health Net Access offers a multidisciplinary program to assist providers in managing the care of pregnant members who are at risk because of medical conditions, social circumstances or non-compliant behaviors. Health Net Access also considers factors, such as noncompliance with prenatal care appointments and medical treatment plans, in determining risk status. Members identified as at risk are reviewed and evaluated for ongoing follow-up during their pregnancy by an obstetric case manager.

A Health Net Access obstetric case manager provides comprehensive care management services to high-risk pregnant members, for the purpose of improving maternal and fetal birth outcomes. The obstetric case manager takes a collaborative approach with all involved in the member's prenatal care, including obstetric providers, primary care providers (PCPs) and specialists, to engage high-risk pregnant members telephonically throughout their pregnancies and postpartum periods.

Members who have high-risk perinatal conditions should be referred to perinatal case management by faxing the member's information to the Health Net Access Case Management Department. These conditions include:

- history of preterm labor before 37 weeks of gestation
- bleeding and blood clotting disorders
- chronic medical conditions
- polyhydramnios or oligohydramnios
- placenta previa, abruption or accrete
- cervical changes

- multiple gestation
- teenage mothers
- hyperemesis
- poor weight gain
- advanced maternal age
- substance abuse
- mental illness
- domestic violence
- non-compliance with obstetric appointments
- members taking prescription opioids

Reporting High-Risk and Non-Compliant Behaviors

Obstetric providers must refer all at risk members to Health Net Access by contacting the Provider Services Center or faxing the member's information to the Health Net Access Case Management Department.

The following situations must be reported to Health Net Access:

- Members who are diabetic and display consistent complacency regarding dietary control and/or use of insulin.
- Members who fail to follow prescribed bed rest.
- Members who fail to take tocolytics as prescribed or do not follow home uterine monitoring schedules.
- Members who admit to or demonstrate continued alcohol and/or other substance abuse.
- Members who show a lack of resources (such as food, shelter and clothing) that could influence their well-being or that of their child.
- Members who frequently visit the emergency department/urgent care setting with complaints of acute pain and request prescriptions for controlled analgesics and/or mood altering medications.
- Members who fail to appear for two or more prenatal visits without rescheduling, or fail to keep rescheduled appointments.
    - Providers should make two attempts to bring the member in for care prior to contacting the Health Net Access Case Management Department.

Maternity Care Provider Requirements

Found in: Operations Manuals > Benefits > Maternity Care Services Effective 05/23/2016

Prior authorization is required at the time of the member's first prenatal visit. The authorization applies to obstetrical care for the duration of the member's pregnancy. Providers must submit the Health Net Access Request for Prior Authorization form at the time of the first prenatal visit.

Providers 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.

Providers are required to identify risk factors by completing a comprehensive tool that covers psychosocial, nutritional, medical, and educational factors, such as the ACOG or Mutual Insurance Company of Arizona (MICA) assessment tool, when submitting the prior authorization request.

Licensed midwives must provide services within their scope of practice.

All providers must adhere to the standards of care established by ACOG, including, but not limited to the following:

- Use of a standardized prenatal medical record and risk assessment tool, such as the ACOG form.
- Documenting all aspects of maternity care.
- Completion of history, including medical and personal health (including infections and exposures), menstrual cycles, past pregnancies and outcomes, family and genetic history.
- Clinical expected date of confinement.
- Performance of physical exam, including determination and documentation of pelvic adequacy.
- Performance of laboratory tests at recommended time intervals.
- Comprehensive risk assessment incorporating psychosocial, nutritional routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded, and an appropriate management plan.
- Antenatal and postpartum depression screening.

All maternity care providers must ensure they do the following:

- Request prior authorization from Health Net Access promptly when members have tested positive for pregnancy.
- Refer high-risk members to a qualified physician and are receiving appropriate care.
- Educate members about health behaviors during pregnancy, including the importance of proper nutrition; smoking cessation; avoidance of alcohol and other harmful substances, including illegal drugs and opioids; screening for sexually transmitted diseases; the physiology of pregnancy; risk assessment and screening for lead exposure, which, in pregnancy, can adversely affect both mother and fetus health; process of labor and delivery; breastfeeding; other infant care information, including selecting a pediatric provider for the baby; and postpartum follow-up.
- Appropriately maintain member medical records and document all aspects of maternity care provided.
- Inform members of voluntary HIV testing and that counseling is available if the test is positive or indeterminate.
- Refer members for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, to support healthy pregnancy outcomes. .
- Notify members 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.
- Provide postpartum services to members within 60 days of delivery.

Additional obstetrical provider requirements include:

- Educating members on healthy behaviors during pregnancy, including: proper nutrition, effects of alcohol and drugs, the physiology of pregnancy, the process of labor and delivery, breast feeding and other infant care information.
- Offering HIV/AIDS testing and confidential post testing counseling to all members.
- Ensuring delivery meets Health Net Access criteria.
- Reminding delivery hospital of requirement to notify Health Net Access on the date of delivery.
- Referring member to Health Net Access case management, and other known support services and community resources, as needed.
- Encouraging members to participate in childbirth classes at no cost to them.
    - The member may call the facility where she will deliver and register for childbirth classes.

Providers may consult with the Health Net Access medical director, or other qualified designee, for members with other conditions that are deemed appropriate for perinatology referral.

In non-emergent situations, all obstetrical care providers must refer members to Health Net Access providers in accordance with the following guidelines:

- Referrals outside the participating provider network must be prior authorized.
- Failure to obtain prior authorization for non-emergent obstetric or out-of-network newborn services will result in claim denials.
- Members may not be billed for covered services if the provider neglects to obtain the appropriate approvals.

Obstetrical Care Appointment Standards

Health Net Access has specific standards for the timing of initial and return prenatal appointments. All obstetric providers must make it possible for members to obtain initial prenatal care appointments within the following time frames:

- Category appointment availability:
    - First trimester - within 14 days of the request for an appointment
    - Second trimester - within 7 days of the request for an appointment
    - Third trimester - within 3 days of the request for an appointment
    - Return visits - return visits should be scheduled routinely after the initial visit

- Members must be able to obtain return prenatal visits:
    - First 28 weeks - every four weeks
    - From 28 to 36 weeks - every two to three weeks
    - From 37 weeks until delivery - weekly

- High-risk pregnancy care appointments - Members must be able to obtain an initial appointment within three days of identification of high-risk by Health Net Access or maternity care provider, or immediately if an emergency exists.

Outreach, Education and Community Resources

Found in: Operations Manuals > Benefits > Maternity Care Services Effective 05/23/2016

Health Net Access is committed to maternity care outreach. The goal of maternity care outreach is to identify pregnant members and begin prenatal care as soon as possible.

PCPs should ask about pregnancy status when members call for appointments and report positive pregnancy tests to Health Net Access. PCPs should provide general education and information about prenatal care, when appropriate, during member office visits. Pregnant members continue to receive primary care services from their assigned PCPs during their pregnancy.

Health Net Access is involved in many community efforts to increase awareness of the need for prenatal care. Health Net Access encourages PCPs to actively participate in these outreach and education activities, including WIC. Providers should encourage members to enroll in this program. Various other services are available in the community to help pregnant women and their families. Contact the Health Net Access Provider Services Center for information about helping patients use these services.

Pregnancy Termination

Found in: Operations Manuals > Benefits > Maternity Care Services Effective 05/23/2016

Pregnancy termination is covered if one of the following conditions is met:

- The pregnant member suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member.

Conditions, Limitations and Exclusions

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination and clinical information that supports the medical necessity for the procedure.

The form must be submitted with the request for prior authorization to the Health Net Access Prior Authorization Department and must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

Additional Required Documentation

- The provider must obtain a written informed consent and keep it in the member's chart for all pregnancy terminations. If the pregnant member is younger than age 18, or is age 18 or older and considered an incapacitated adult, a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.
- When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed.
- When mifepristone is administered, the following documentation is also required:
  - Duration of pregnancy in days.
  - The date intrauterine device (IUD) was removed if the member had one.
  - The date mifepristone was given.
  - The date misoprostol was given.
  - Documentation that pregnancy termination occurred.

Prior Authorization

Except in cases of medical emergencies, the provider must obtain prior authorization for all covered pregnancy terminations. When pregnancy termination is considered due to rape or incest, or because the mother's health is in jeopardy secondary to medical complications, fax a prior authorization request to 1-866-295-9729 along with the lab, radiology, consultation, and other test results that support the medical necessity for the procedure, including:

- A copy of the member's medical record.
- A completed and signed copy of the Certificate of Necessity for Pregnancy Termination.
- Written explanation of the reason that the procedure is medically necessary. For example, the pregnancy is:

  - Creating a serious physical or mental health problem for the pregnant member.
  - Seriously impairing a bodily function of the pregnant member.
  - Causing dysfunction of a bodily organ or part of the pregnant member.
  - Exacerbating a health problem of the pregnant member.
  - Preventing the pregnant member from obtaining treatment for a health problem.

- If the pregnancy termination is requested as a result of incest or rape, providers must also include identification of the proper authority to which the incident was reported, including the name of the agency, the report number and the date the report was filed.

All terminations requested for minors must include a signature of a parent or legal guardian or a certified copy of a court order.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Health Net Access Prior Authorization Department within two business days of the date on which the pregnancy termination procedure was performed.

The Health Net Access medical director or qualified designee reviews all requests for medically necessary pregnancy terminations.

Related Services with Special Policies

Found in: Operations Manuals > Benefits > Maternity Care Services Effective 07/01/2013

Covered related services with special policy and procedural guidelines include, but are not limited to:

- Routine circumcision of newborn male infants, which is not a covered service unless it is determined to be medically necessary (ARS 36-2907(b))
- Inpatient hospital stays
  - For members under age 21, Health Net Access covers up to 48 hours of inpatient hospital care for a normal vaginal delivery and up to 96 hours of inpatient hospital care for a cesarean delivery
  - For members age 21 and older, Health Net Access covers up to 48 hours of inpatient hospital care for a normal vaginal delivery and up to 96 hours of inpatient hospital care for a cesarean delivery to the extent that the stay does not exceed the 25-day inpatient hospital stay limit
  - Prior authorization is not required for hospitalizations that do not exceed 48 hours of inpatient hospital care for a normal vaginal delivery or 96 hours for a cesarean delivery
  - A newborn may be granted an extended stay in the hospital of birth when the mother's stay in the hospital is medically necessary beyond a 48-/96-hour stay. If the mother's stay in the hospital exceeds the 25-day inpatient limit, the newborn may be granted an extended stay and is not subject to the 25-day inpatient limit

- Home uterine monitoring - Medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization, is a covered benefit
- Labor and delivery services provided in freestanding birthing centers
  - Services rendered in a freestanding birthing center must be provided by a physician (the member's primary care physician (PCP) or obstetrician with hospital admitting privileges) or by a registered nurse midwife who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services
  - Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center

- Labor and delivery services provided in a home setting
  - Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated to deliver in the member's home
  - Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery

- Licensed midwife services
  - Licensed midwife services may only be provided to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The age of the member must be included as a consideration in the risk status evaluation
  - Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution

Medical Food

Found in: Operations Manuals > Benefits Effective 07/01/2013

Medical Food

Found in: Operations Manuals > Benefits > Medical Food Effective 05/18/2016

Health Net Access covers medical foods when medically necessary for Health Net Access members diagnosed with one of the following inherited metabolic conditions:

- phenylketonuria
- homocystinuria
- maple syrup urine disease
- galactosemia (requires soy formula)
- beta keto-thiolase deficiency
- citrullinemia
- glutaric acidemia type I
- 3 methylcrotonyl CoA carboxylase deficiency
- isovaleric acidemia
- methylmalonic acidemia
- propionic acidemia
- arginosuccinic acidemia
- tyrosinemia type I
- HMG CoA lyase deficiency
- cobalamin A, B, C deficiencies

Medical foods are metabolic formula or modified low-protein foods produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is covered for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

Upon completion of the member's initial consultation with a genetics physician and metabolic nutritionist, and the determination that metabolic formula and/or low-protein foods are necessary to meet the member's nutritional needs, providers forward the request for metabolic nutrition to the Health Net Access Prior Authorization unit for review and processing. All approvals and payments for medical foods are the responsibility of Health Net Access.

Member Transfers Between Facilities

Found in: Operations Manuals > Benefits Effective 07/01/2013

Neonate Transfers between Acute Care Facilities

Found in: Operations Manuals > Benefits > Member Transfers Between Facilities
Effective 07/01/2013

Acutely ill neonates may be transferred from one acute care center to another, given certain conditions. The chart that follows provides the levels of care, conditions appropriate for transfer, and criteria for transfer.

Level of Care		Transfer Criteria
From	To	
Primary	Secondary	1. The nursing and medical staff of the sending hospital cannot provide: • The level of care needed to manage the infant beyond stabilization to transport • The required diagnostic evaluation and consultation services needed 2. Transportation orders specify the type of transport, the training level of the transport crew and the level of life support
	Tertiary	Same as above
Secondary	Tertiary	Same as above
	Primary	Same as below

Tertiary	Tertiary (rare)	1. The sending and receiving neonatalogists (and surgeons, if involved) have spoken and agreed that the transfer is safe. 2. The infant is expected to remain stable, considering the period of time required for the distance to be traveled. 3. Transport orders specify the type of transport and training level of the transport crew. 4. A transfer summary accompanies the infant.
	Secondary	Same as above
	Primary	Same as above

Transfers Following Emergency Hospitalization

Found in: Operations Manuals > Benefits > Member Transfers Between Facilities

Effective 07/01/2013

Transfers initiated by Health Net Access between inpatient hospital facilities may be made when the following conditions are met:

- The attending emergency physician, or the provider treating the member, determines that the member is sufficiently stabilized for transfer and will remain stable for the period of time required for the distance to be traveled
- The receiving physician agrees to the member transfer
- Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life-support
- A transfer summary accompanies the member

Transfer to a lesser level of care facility may be made when one or more of the following criteria are met:

- Member's condition does not require full acute hospital capabilities for diagnostic and/or treatment procedures
- Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in an acute care hospital

The attending emergency physician or the provider treating the member and Health Net Access' medical director or designee are responsible for determining whether a particular case meets criteria established in policy. In the event the treating provider requests a decision by the Arizona Health Care Cost Containment System (AHCCCS) on the transfer of a particular member, AHCCCS applies the criteria listed in the AHCCCS Medical Policy Manual (AMPM), Chapter 500, Policy 530 and Arizona Revised Statute 36-2909(B).

Non-Physician Surgical First Assistant Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Non-Physician Surgical First Assistant Services

Effective 07/01/2013

Health Net Access covers services provided by non-physician surgical first assistants who are licensed in Arizona as a physician's assistant or registered nurse, and who are registered as an Arizona Health Care Cost Containment System (AHCCCS) provider, and contracting and credentialed with Health Net Access to render non-physician surgical first services.

Nutritional Therapy

Found in: Operations Manuals > Benefits Effective 07/01/2013

Nutritional Assessment and Nutritional Therapy

Found in: Operations Manuals > Benefits > Nutritional Therapy Effective 07/01/2013

Nutritional assessments are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for Health Net Access members under age 21, whose health

status may improve with nutrition intervention. Nutritional therapy is covered for EPSDT-eligible Health Net Access members for the below enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

- Enteral nutritional therapy - Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube
- Parenteral nutritional therapy - Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength
- Commercial oral supplemental nutritional feedings - Provides nourishment and increases caloric intake as a supplement to the member's intake of other age-appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription

Health Net Access covers the following for members with a medical condition described in the section above:

- Special Supplemental Program for Women, Infants and Children (WIC)-eligible infant formulas, including specialty infant formulas
- Medical foods
- Parenteral feedings
- Enteral feedings

Refer to the Medical Foods section for Health Net Access members with a congenital metabolic disorder, such as phenylketonuria, homocystinuria, maple syrup urine disease, or galasctosemia.

Nutritional Assessment and Nutritional Therapy - Members Ages 21 and Older

Found in: Operations Manuals > Benefits > Nutritional Therapy Effective 05/18/2016

Nutritional assessments and nutritional therapy is provided for members whose health status may improve with nutrition intervention. Arizona Health Care Cost Containment System (AHCCCS) covers nutritional therapy on an enteral, parenteral and oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

Nutritional assessments and nutritional therapy are covered benefits for members ages 21 and older when all of the following apply:

- The member is currently underweight with a BMI of less than 18.5 presenting serious health consequences for the member, or the member has demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
- The member is able to consume no more than 25 percent of his or her nutritional requirements from typical food sources.
- The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions or psychosocial problems, or endocrine or gastrointestinal problems).
- The member has had a trial of higher caloric foods, blenderized foods or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. After this trial, there is clinical documentation and other supporting evidence indicating that higher caloric foods would be detrimental to the member's overall health.

Referrals for Nutritional Assessment

Nutritional assessments are conducted to assist members whose health status may improve with nutritional intervention. Health Net Access covers the assessment of nutritional status, as determined necessary and as a part of health risk assessment and screening services provided by the member's primary care provider (PCP). Nutritional assessment services provided by a registered dietitian are covered when ordered by the member's PCP.

To initiate a referral for a nutritional assessment, complete the Health Net Access Referral form and fax it to the Health Net Access Prior Authorization Department.

Prior Authorization

Providers must submit all clinically relevant information for medical necessity review and prior authorization requests. To obtain prior authorization for commercial oral nutritional supplements (medical foods), providers must complete and submit the

Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form and Request for Prior Authorization form in its entirety to the Health Net Access Prior Authorization Department.

Nutritional Assessment and Referral

Found in: Operations Manuals > Benefits > Nutritional Therapy Effective 07/01/2013

The assessment of a Health Net Access member's nutritional status is covered as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program specified in the Arizona Health Care Cost Containment System (AHCCCS) EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's primary care provider (PCP). This includes members who are under or overweight. A PCP may perform the nutritional assessment or may refer the member to a registered dietician.

To initiate a referral for a nutritional assessment, complete the Health Net Access referral form and fax to the Health Net Access Prior Authorization Department. If the nutritional assessment is ordered by the member's PCP, prior authorization is not required.

Prior Authorization

Found in: Operations Manuals > Benefits > Nutritional Therapy Effective 07/01/2013

Prior authorization is always required for nutritional therapy. Providers must submit all clinically relevant information for medical necessity review and prior authorization requests. To obtain prior authorization for enteral or parenteral nutritional therapy, providers must complete and submit a Request for Prior Authorization form to the Health Net Access Prior Authorization Department.

Commercial Oral Supplemental Nutritional Feedings

Prior authorization is required for commercial oral supplemental nutritional feedings, including specialty infant formulas, unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder.

The primary care physician (PCP) or attending physician must determine medical necessity on an individual basis for commercial oral nutritional supplements, using the specified criteria below.

Certificate of Medical Necessity for Commercial Oral Nutritional Supplements

For prior authorization on commercial oral supplemental nutritional feedings, the member's PCP or attending physician must complete and submit the Arizona Health Care Cost Containment System (AHCCCS)-approved Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form to the Health Net Access Prior Authorization Department.

The PCP or attending physician must have documentation that nutritional counseling was provided as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and specify alternatives that were tried in an effort to boost caloric intake and change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The PCP or attending physician must indicate on the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form which criteria were met when assessing medical necessity of providing commercial oral nutritional supplements. The member must meet at least two of the following criteria:

- At or below the 10th percentile on the appropriate growth chart for his or her age and gender for three months or more
- Reached a plateau in growth and/or nutritional status for more than six months (prepubescent)
- Already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)
- Able to consume/eat no more than 25 percent of his or her nutritional requirements from age-appropriate food sources
- Has absorption problems as evidenced by emesis, diarrhea, dehydration, and weight loss; and intolerance to milk or formula products has been ruled out
- Requires nutritional supplements on a temporary basis due to an emergent condition; such as post-hospitalization (prior authorization is not required for the first 30 days)
- At high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition

Observation Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Observation Services Effective 07/01/2013

Observation services are reasonable and necessary services provided on a hospital's premises, on an outpatient basis, for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include use of a bed, periodic monitoring by a hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of significant instability or disability on an outpatient basis.

Observation services do not apply when a member with a known diagnosis enters a hospital for a scheduled procedure or treatment that is expected to keep the member in the hospital for less than 24 hours. This is considered an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight. Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation services must be ordered in writing by a physician or other individual authorized to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for observation services as long as medical necessity exists. Factors taken into consideration when ordering observation services include:

- Severity of the patient's signs and symptoms
- Degree of medical uncertainty where the patient may experience an adverse occurrence
- Need for diagnostic studies that appropriately are outpatient services (their performance does not ordinarily require the member to remain in the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted
- The availability of diagnostic procedures at the time and location where the patient presents
- It is reasonable, cost-effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission
- Length of stay observation services are medically necessary for the patient's condition

The medical record must document the basis for the observation services and at a minimum must include:

- Physician notes
  - Condition necessitating observation
  - Justification of need to continue observation
  - Discharge plan
- Medical records documentation
  - Written orders for observation services
  - Written follow-up orders at least every 24 hours
  - Changes from *observation to inpatient* or *inpatient to observation*
  - Changes from inpatient to observation must occur within 12 hours after admission as an inpatient and have supporting medical documentation
  - Physician's daily written progress notes

Physician Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Physician Services Effective 09/15/2015

Health Net Access covers physician services for all members within certain limits based on member age and eligibility. Physician services include medical assessment, treatment and surgical services performed in the office, clinic, hospital, home, nursing facility, or other location by a licensed doctor of medicine or osteopathy.

Covered Services

- Services as appropriate to the member's medical need and physician's scope of practice
- Complete physical examinations for new members to determine disease risk, provide early detection and establish a prevention or treatment plan
- Annual periodic examinations to monitor health status

Limitations

The following physician services are not covered:

- Services not directly related to medical care, such as physician visits to a nursing facility for the purpose of 30-60 day certification
- Moderate sedation (conscious sedation) performed by the physician performing the underlying procedure for which sedation is desired for members age 21 and over
- Monitored anesthesia care, including all levels of sedation, provided by qualified anesthesia personnel (physician anesthesiologist or certified nurse anesthetist)
- Allergic immunotherapy - Except for members under age 21 under EPSDT when medically necessary and as described below, allergy testing and immunotherapy, including testing for common allergens and desensitization treatments administered via subcutaneous injections (such as allergy shots), sublingular immunotherapy (such as slits) or via other routes of administration for adults ages 21 and older

  Exceptions
  - Allergy testing is covered in instances when a member has either sustained an anaphylactic reaction to an unknown allergen or has exhibited such a severe allergic reaction (such as severe facial swelling, breathing difficulties, epiglottal swelling, or extensive (not localized) urticaria) that it is reasonable to assume further exposure to the unknown allergen may result in a life-threatening situation. In such instances, allergy testing is covered to identify the unknown allergen
  - Self-administered epinephrine or similar treatment modalities is covered for members with a history of previous severe allergic reactions, whether the specific cause of that reaction has been identified. These testing and treatment limitations do not apply to over-the-counter medications or prescriptions intended to treat allergy symptoms. Such medications are covered for affected members in accordance with the pharmacy benefit and prior authorization requirements

- Medical marijuana - Health Net Access does not cover office visits or any other services that are primarily for the purpose of determining whether a member would benefit from medical marijuana

Rehabilitation Therapy

Found in: Operations Manuals > Benefits Effective 01/01/2003

Occupational Therapy

Found in: Operations Manuals > Benefits > Rehabilitation Therapy Effective 07/01/2013

Occupational therapy services are medically prescribed treatments to improve or restore functions that have been impaired by illness or injury, or that have been permanently lost or reduced by illness or injury. Occupational therapy is intended to improve the member's ability to perform tasks required for independent functioning. Prior authorization for occupational therapy is required.
Health Net Access covers medically necessary inpatient occupational therapy services for all members. Outpatient occupational therapy services are covered only for members under age 21 receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, KidsCare members and Arizona Long-Term Care System (ALTCS) members.

Inpatient occupational therapy consists of evaluation and therapy. Therapy services may include:

- Cognitive training
- Exercise modalities
- Hand dexterity
- Hydrotherapy
- Joint protection
- Manual exercise
- Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device, or splint
- Perceptual motor testing and training
- Reality orientation
- Restoration of activities of daily living
- Sensory re-education

- Work simplification and/or energy conservation

Physical Therapy

Found in: Operations Manuals > Benefits > Rehabilitation Therapy Effective 03/01/2014

Physical therapy is a covered service when provided by, or under the supervision of, a registered physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

Health Net Access covers medically necessary physical therapy services for all members. Physical therapy is covered on an inpatient and outpatient basis. Outpatient physical therapy visits are limited to both 15 visits to restore a level of function and 15 visits to maintain or help achieve a level of function per contract year (October 1 - September 30) for adult members ages 21 and older who are not Medicare-eligible. For those members who are also Medicare recipients, refer to the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual, Chapter 300, Exhibit 300-3C regarding the outpatient physical therapy limit.

Speech Therapy

Found in: Operations Manuals > Benefits > Rehabilitation Therapy Effective 07/01/2013

Speech therapy is the medically prescribed provision of diagnostic and treatment services provided by or under the direct supervision of a qualified speech pathologist. Prior authorization is required.

Health Net Access covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's primary care physician (PCP). Speech therapy provided on an outpatient basis is covered only for members under age 21 receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, KidsCare and ALTCS members.

Inpatient speech therapy consists of evaluation and therapy. Therapy services may include:

- Articulation training
- Auditory training
- Cognitive training
- Esophageal speech training
- Fluency training
- Language treatment
- Lip reading
- Non-oral language training
- Oral-motor development
- Swallowing training

Respiratory Therapy

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Respiratory Therapy Effective 07/01/2013

Respiratory therapy is a covered treatment ordered by the attending physician to restore, maintain or improve respiratory functioning.

Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures, observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care, diagnostic testing and treatment, and implementing appropriate reporting and referral protocols.

Health Net Access covers medically necessary respiratory services for all members on both an outpatient and inpatient basis. Services must be provided by a qualified respiratory practitioner under ARS §32-3501, respiratory therapist or respiratory therapy technician, licensed by the Arizona Board of Respiratory Care Examiners.

Skilled Nursing Facility Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Overview

Found in: Operations Manuals > Benefits > Skilled Nursing Facility Services Effective 05/18/2016

Health Net Access covers medically necessary services provided in contracting skilled nursing facilities (SNFs) for members who need defined nursing care 24 hours a day, but who do not require acute hospital care under the daily direction of a physician.

Prior authorization is required for SNF services prior to admission, except in those cases for which retro-eligibility precludes the ability to obtain prior authorization. In these cases, the case is subject to medical review.

Medically necessary SNF services are covered for a period not to exceed 90 days per contract year (October 1 to September 30). The following criteria apply:

- A participating physician has ordered SNF services.
- The medical condition of the member is such that if SNF services are not provided, it would result in hospitalization, or the treatment is such that it cannot be rendered safely in a less restrictive setting, such as at home by a home health services provider.
- The 90 days of coverage is per member, per contract year and does not restart if the member transfers to a different nursing facility. Health Net Access members residing in a SNF at the beginning of a new contract year begin a new 90-day coverage period. Unused days do not carry over.
- The 90 days of coverage begins on the day of admission regardless of whether the member is covered by a third-party insurance carrier, including Medicare.
- If the member has applied for Arizona Long Term Care System (ALTCS) and a decision is pending, Health Net Access must notify the ALTCS eligibility administrator when the member has been residing in the nursing facility for 60 days. This allows time to follow-up on the status of the ALTCS application.
- If the member becomes ALTCS-eligible and is enrolled with the ALTCS program before the end of the maximum 90 days of coverage, Health Net Access is only responsible for the SNF coverage during the time the member is enrolled with Health Net Access. The SNF must coordinate with the member or his or her representative on alternate methods of payment for continuation of services beyond the 90-day coverage with Health Net Access until the member is enrolled in the ALTCS program or until the beginning of the new contract year.

Care Coordination

Participating providers should identify and refer potentially eligible Health Net Access member to ALTCS. If a Health Net Access member is referred to and approved for ALTCS enrollment, Health Net Access coordinates the transition with the assigned ALTCS contractor to assure continuity and quality of care is maintained during and after the transition.

Limitations

Services that are not covered separately when provided in a SNF include:

- Nursing services, including:
  - medication administration
  - tube feedings
  - personal care services
  - routing testing of vital signs and blood glucose monitoring
  - assistance with eating
  - catheter maintenance
- Basic patient care equipment and sickroom supplies, such as bedpans, urinals, diapers, bathing and grooming supplies, walkers, and wound dressings or bandages.
- Dietary services, including, but not limited to, preparation and administration of special diets and adaptive tools for eating.
- Administrative physician visits made solely for the purpose of meeting state certification requirements.
- Non-customized durable medical equipment (DME) and supplies, such as manual wheelchairs, geriatric chairs and bedside commodes.
- Rehabilitation therapies ordered as a maintenance regimen.
- Administration, medical director services, plant operations, and capital.
- Over-the-counter medications and laxatives.
- Social activity, recreational and spiritual services.
- Any other services, supplies or equipment that are state or county regulatory requirements or are included in the SNF's room and board charge.

Sleep Studies (Polysomnography)

Found in: Operations Manuals > Benefits Effective 07/01/2013

Coverage Explanation

Found in: Operations Manuals > Benefits > Sleep Studies (Polysomnography) Effective 07/01/2013

Health Net Access provides benefits for standard polysomnography inpatient and outpatient sleep studies in the following settings:

- A licensed and certified hospital facility
- A nonhospital facility that meets one of the following sets of criteria:
  - Is licensed by the Arizona Department of Health Services (ADHS) and the facility is accredited by the American Academy of Sleep Medicine
  - Has a medical director who is certified by the American Board of Sleep Medicine and has a managing sleep technician who is registered by the Board of Registered Polysomnographic Technologists
  - For sleep electroencephalogram (EEG) only, the facility must have a physician who is a board-certified neurologist. No ADHS license is required

Criteria for Coverage

Standard polysomnography is covered in the following indications:

- Suspected sleep-related breathing disorders, such as obstructive sleep apnea (OSA), when one of the following two criteria are met:
  - Witnessed apnea during sleep greater than 10 seconds in duration
  - Suspected sleep-related breathing disorders, such as obstructive sleep apnea (OSA) when one of the following two criteria are met:
    - Excessive daytime sleepiness - Must rule out as a cause for these symptoms: poor sleep hygiene, medication, drugs, alcohol, hypothyroidism, other medical diagnoses, psychiatric or psychological disorders, social or work schedule changes
    - Persistent or frequent snoring
    - Obesity (body mass index (BMI) greater than 30 kg/M^2 or hypertension)
    - Choking or gasping episodes associated with awakenings
  - Suspected narcolepsy, demonstrated by symptoms, such as sleep paralysis, hypnagogic hallucinations and cataplexy
  - Suspected period movement disorder, including excessive daytime sleepiness together with witnessed periodic limb movements of sleep
  - Suspected parasomnias that are unusual or atypical based on patient's age, frequency or duration of behavior
  - Suspected restless leg syndrome, when uncertainty exists in the diagnosis
  - To assist with the diagnosis of paroxysmal arousals or other sleep disruptions that are thought to be seizure-related when the initial clinical evaluation and results of a standard EEG are inclusive
  - Under limited circumstances, titration of positive airway pressure in adults with a documented diagnosis of OSA for whom positive airway pressure has been approved
  - Other health conditions in which sleep studies have been shown to be medically necessary for their proper diagnosis or treatment

The preferred method is a split night study in which the sleep study is performed during the first half of the night and positive air pressure system, such as continuous positive airway pressure (CPAP) or biphasic intermittent positive airway pressure (BiPAP), titration is performed during the second half of the night.

In cases where testing and titration cannot be completed in one session, Health Net Access may authorize a second night subject to medical necessity criteria.

Limitations

- Polysomnography is not covered for the following symptoms or conditions existing alone in the absence of other features suggestive of OSA:
  - Snoring
  - Obesity
  - Hypertension
  - Morning headaches
  - Decrease in intellectual functions
  - Memory loss
  - Frequent nighttime awakenings
  - Other sleep disturbances, such as insomnia (acute or chronic), night terrors, sleep walking, epilepsy where nocturnal seizures are not suspected
  - Common uncomplicated non-injurious parasomnias
- Follow-up sleep studies are not covered unless the member's condition has changed significantly and those changes are likely to modify the need for CPAP or other treatments
- Sleep studies performed in the home or in a mobile unit are not covered
- Pulse oximetry alone as a sleep study is not covered
- Repeat polysomnography in follow-up patients with OSA treated with CPAP when symptoms attributable to sleep study have resolved is not covered

Telehealth and Telemedicine

Found in: Operations Manuals > Benefits Effective 07/01/2013

Coverage Information

Found in: Operations Manuals > Benefits > Telehealth and Telemedicine Effective 07/01/2013

Overview

Health Net Access covers medically necessary consultative and/or treatment telemedicine services for all eligible members within the limitations described in this policy when provided by an appropriate Arizona Health Care Cost Containment System (AHCCCS) registered provider.

Definitions

Term	Definition
Consulting provider	Any AHCCCS provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member
Store and forward	The transmission of a patient's medical information from the originating site to the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present
Telehealth	The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance • Telemedicine - The practice of health care delivery, diagnosis, consultation and treatment, and the transfer of medical data between the originating and distant sites through real-time interactive audio, video or data communications that occur in the physical presence of the member • Telecommunications technology (which includes store and forward) - Transfer of medical data from one site to another through the use of a camera, electronic data collection system, such as an electrocardiogram (ECG) or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but not requiring the member to be present during their implementation, are not considered telemedicine
Distant site	The location of the telemedicine consulting provider, which is considered the place of service
Originating site	The location where the member is receiving the telemedicine service
Telepresenter	A designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily medically expert, with the member's medical condition in order to present the case accurately

Use of Telemedicine

For the services listed below, Health Net Access provides benefits for medically necessary services provided via telemedicine. Services must be real-time visits otherwise reimbursed by Health Net Access. Both the member and the originating provider or knowledgeable telepresenter must be present. Prior authorization is not required when covered services are provided as described in this section.

The following medical services are covered:

- Cardiology
- Dermatology
- Endocrinology
- Hematology/oncology
- Infectious diseases
- Neurology

- Obstetrics/gynecology
- Oncology/radiation
- Ophthalmology
- Orthopedics
- Pain clinic
- Pathology
- Pediatrics and pediatric subspecialties
- Radiology
- Rheumatology
- Surgery follow-up and consultations
- Behavioral health
- Diagnostic consultation and evaluation
    - Psychotropic medication adjustment and monitoring
    - Individual and family counseling
    - Case management

Use of Telecommunications

Services delivered using telecommunications are generally not covered by Health Net Access as telemedicine services. The exceptions to this are described below:

- A provider in the role of telepresenter may be providing a separately billable service under the scope of practice, such as performing an ECG or an X-ray. In this case, the separately billable service is covered, but the specific act of telepresenting is not covered
- A consulting provider at the distant site may offer a service that does not require real-time interaction with the member. Reimbursement for this type of service is limited to dermatology, radiology, ophthalmology, and pathology, and is subject to review by Health Net Access medical management. The consulting physician should bill covered services using modifier GQ
- In the special circumstance of the onset of acute stroke symptoms within three hours of presentation,
  Health Net Access recognizes the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when the member presents within three hours of onset of stroke symptoms, Health Net Access reimburses the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patient's condition is such that real-time video interaction cannot be achieved due to an effort to expedite care

Conditions, Limitations and Exclusions

- Both the referring and consulting providers must be registered with AHCCCS
- A consulting service delivered via telemedicine by other than an Arizona registered provider licensed to practice in the state or jurisdiction from which the consultation is provided or, if employed by an Indian Health Services (IHS), tribal or urban Indian health program, be appropriately licensed based on IHS and 638 tribal facility requirements
- At the time of service delivery via real-time telemedicine, the member's health care provider may designate a trained telepresenter to present the case to the consulting provider if the member's primary care physician (PCP) or attending physician, or other medical professional who is familiar with the member's medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary, but no payment is made for such questions
- Health Net Access provides benefits for nonemergency transportation to and from the telemedicine originating site to receive a medically necessary covered consultation or treatment service

Transplants

Found in: Operations Manuals > Benefits Effective 04/18/2013

Covered Services

Found in: Operations Manuals > Benefits > Transplants Effective 07/01/2013

The following describes covered services for transplants under the Health Net Access product:

- Health Net Access covers medically necessary transplants based on Arizona Health Care Cost Containment System (AHCCCS) direction. In order to be covered, a transplant must be medically necessary, cost effective, and federally and state reimbursable. Arizona state laws and regulations specifically address transplant

services and related topics as follows: Specific non-experimental transplants which are approved for reimbursement are covered services (Arizona Revised Statute (ARS) §36-2907)
- Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (Arizona Administrative Code (AAC) R9-22-202)
- Medically necessary is defined as those covered services "provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions, or their progression, or prolong life" (AAC R9-22-101)
- Experimental services as defined in AAC R9-22-203
- Standard of care is defined as "a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community" (AAC R9-22-101)

Transplant coverage is limited for members ages 21 and older; however, Health Net Access covers all medically necessary, non-experimental transplants for members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Transplants are excluded for members who are eligible for only emergency services under the Federal Emergency Services Program.

Covered transplants must meet nationally recognized criteria for nonexperimental, noninvestigational and not primarily for purposes of research. Details of transplant coverage and criteria are available in the AHCCCS Medical Policy Manual located on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-DD.

Covered Transplants for Members Ages 21 and Older

The following organ and tissue transplant services are covered for members ages 21 and older if prior authorized and coordinated with Health Net Access:

- Heart, including transplants for the treatment of non-ischemic cardiomyopathy
- Lung
- Liver, including transplants for patients with Hepatitis C
- Kidney (cadaveric and liver donor)
- Simultaneous pancreas/kidney (SPK)
- Pancreas after a kidney transplant (PAK)
- Autologous and allogeneic related and unrelated hematopoietic cell transplants
- Cornea
- Bone

Health Net Access may consult with the AHCCCS consultant for guidance in those cases requiring medical determinations. If Health Net Access does not use the AHCCCS consultant, Health Net Access obtains its own expert opinion.

Non-Covered Transplants for Members Ages 21 and Older

- Pancreas only, if not performed simultaneously with or following a kidney transplant
- Partial pancreas (including autologous and allogeneic islet cell transplants)
- Visceral transplantation
    - Intestine alone
    - Intestine with pancreas
    - Intestine with liver
    - Intestine, liver, pancreas en bloc
- Any other transplants not specifically listed under Covered Transplants for Members Ages 21 and Older

Where there is a transplant of multiple organs, only the covered transplants are reimbursed.

The following transplant and transplant-related services are not covered when the transplant procedure itself is not covered:

- Artificial or mechanical hearts or xenografts
- Workups to evaluate the patient as a possible transplant candidate
- Hospitalization for the above procedures
- Organ procurement

Transplant Services and Settings

Transplant services are covered only when performed in specific settings, as follows:

- Solid organ transplantation services must be provided in a Centers for Medicare and Medicaid Services (CMS) certified transplant center that is contracted with AHCCCS and that is also a United Network for Organ Sharing (UNOS) approved transplant center, unless otherwise approved by Health Net Access, and/or the AHCCCS chief medical officer (CMO), AHCCCS medical director or designee
- Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation and is contracted with AHCCCS, unless otherwise approved by Health Net Access and/or the AHCCCS chief medical officer (CMO), AHCCCS medical director or designee

Assessment for Transplant Consideration

The first step in the assessment for transplant consideration is the initial evaluation by the member's primary care physician (PCP) and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant consideration, the PCP and/or specialist must determine that all of the following conditions are satisfied:

- The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant
- There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member
- There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (such as, chemotherapy and immunosuppressive therapy)
- There is sufficient social support to ensure the member's compliance with treatment recommendations, such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits. For a pediatric/adolescent member, there is adequate evidence that the member and parent or guardian will adhere to the rigorous therapy, daily monitoring and re-evaluation schedule after transplant
- The member has been adequately screened for potential comorbid conditions that may impact the success of the transplant. When the member's medical condition is such that the evaluation must proceed immediately, the screenings may be provided by the PCP concurrent with the transplant evaluation
- The member's condition has failed to improve with all other conventional medical and surgical therapies. The likelihood of survival with transplantation, considering the member's diagnosis, age and comorbidities, is greater than the expected survival rate with conventional therapies. This information must be documented and submitted to Health Net Access at the time of request for evaluation

Exception for Transplant and Cancer Cases

For members who require medically necessary dental services as a prerequisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions, and the provision of simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. Benefits are provided for these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

AHCCCS Covered Solid Organ and Hematopoietic Stem Cell Transplants

Only solid organ and hematopoietic stem cell transplants that are AHCCCS covered services when medically necessary, cost effective, nonexperimental, and not primarily for purposes of research, are covered under the Health Net Access product. Live donor kidney transplants are covered for pediatric and adult members. Live donor transplants may be considered on a case-by-case basis for solid organs, other than kidney, when medically appropriate and cost effective. Detailed criteria regarding specific transplants are found under the heading *Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations* located in the Medical Policy Manual on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-DD.

Other Transplants and Devices

Following is additional information on coverage for other transplants and devices under the Health Net Access product.

- Circulatory Assist Device (CAD) is an AHCCCS covered service when used as a bridge to transplantation and other specific criteria are met, when medically necessary and prior authorized by Health Net Access. Refer to *Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations* located in the Medical Policy Manual on the AHCCCS website at

www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-DD
- Bone grafts and corneal transplants are AHCCCS covered services, based on medical necessity and prior authorized by Health Net Access

Transplants

Found in: Operations Manuals > Benefits Effective 04/18/2013

Covered Services

Found in: Operations Manuals > Benefits > Transplants Effective 07/01/2013

The following describes covered services for transplants under the Health Net Access product:

- Health Net Access covers medically necessary transplants based on Arizona Health Care Cost Containment System (AHCCCS) direction. In order to be covered, a transplant must be medically necessary, cost effective, and federally and state reimbursable. Arizona state laws and regulations specifically address transplant services and related topics as follows: Specific non-experimental transplants which are approved for reimbursement are covered services (Arizona Revised Statute (ARS) §36-2907)
- Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (Arizona Administrative Code (AAC) R9-22-202)
- Medically necessary is defined as those covered services "provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions, or their progression, or prolong life" (AAC R9-22-101)
- Experimental services as defined in AAC R9-22-203
- Standard of care is defined as "a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community" (AAC R9-22-101)

Transplant coverage is limited for members ages 21 and older; however, Health Net Access covers all medically necessary, non-experimental transplants for members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Transplants are excluded for members who are eligible for only emergency services under the Federal Emergency Services Program.

Covered transplants must meet nationally recognized criteria for nonexperimental, noninvestigational and not primarily for purposes of research. Details of transplant coverage and criteria are available in the AHCCCS Medical Policy Manual located on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-DD.

Covered Transplants for Members Ages 21 and Older

The following organ and tissue transplant services are covered for members ages 21 and older if prior authorized and coordinated with Health Net Access:

- Heart, including transplants for the treatment of non-ischemic cardiomyopathy
- Lung
- Liver, including transplants for patients with Hepatitis C
- Kidney (cadaveric and liver donor)
- Simultaneous pancreas/kidney (SPK)
- Pancreas after a kidney transplant (PAK)
- Autologous and allogeneic related and unrelated hematopoietic cell transplants
- Cornea
- Bone

Health Net Access may consult with the AHCCCS consultant for guidance in those cases requiring medical determinations. If Health Net Access does not use the AHCCCS consultant, Health Net Access obtains its own expert opinion.

Non-Covered Transplants for Members Ages 21 and Older

- Pancreas only, if not performed simultaneously with or following a kidney transplant
- Partial pancreas (including autologous and allogeneic islet cell transplants)
- Visceral transplantation
  - Intestine alone
  - Intestine with pancreas
  - Intestine with liver
  - Intestine, liver, pancreas en bloc

- Any other transplants not specifically listed under Covered Transplants for Members Ages 21 and Older

Where there is a transplant of multiple organs, only the covered transplants are reimbursed.

The following transplant and transplant-related services are not covered when the transplant procedure itself is not covered:

- Artificial or mechanical hearts or xenografts
- Workups to evaluate the patient as a possible transplant candidate
- Hospitalization for the above procedures
- Organ procurement

Transplant Services and Settings

Transplant services are covered only when performed in specific settings, as follows:

- Solid organ transplantation services must be provided in a Centers for Medicare and Medicaid Services (CMS) certified transplant center that is contracted with AHCCCS and that is also a United Network for Organ Sharing (UNOS) approved transplant center, unless otherwise approved by Health Net Access, and/or the AHCCCS chief medical officer (CMO), AHCCCS medical director or designee
- Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation and is contracted with AHCCCS, unless otherwise approved by Health Net Access and/or the AHCCCS chief medical officer (CMO), AHCCCS medical director or designee

Assessment for Transplant Consideration

The first step in the assessment for transplant consideration is the initial evaluation by the member's primary care physician (PCP) and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant consideration, the PCP and/or specialist must determine that all of the following conditions are satisfied:

- The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant
- There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member
- There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (such as, chemotherapy and immunosuppressive therapy)
- There is sufficient social support to ensure the member's compliance with treatment recommendations, such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits. For a pediatric/adolescent member, there is adequate evidence that the member and parent or guardian will adhere to the rigorous therapy, daily monitoring and re-evaluation schedule after transplant
- The member has been adequately screened for potential comorbid conditions that may impact the success of the transplant. When the member's medical condition is such that the evaluation must proceed immediately, the screenings may be provided by the PCP concurrent with the transplant evaluation
- The member's condition has failed to improve with all other conventional medical and surgical therapies. The likelihood of survival with transplantation, considering the member's diagnosis, age and comorbidities, is greater than the expected survival rate with conventional therapies. This information must be documented and submitted to Health Net Access at the time of request for evaluation

Exception for Transplant and Cancer Cases

For members who require medically necessary dental services as a prerequisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions, and the provision of simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. Benefits are provided for these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

AHCCCS Covered Solid Organ and Hematopoietic Stem Cell Transplants

Only solid organ and hematopoietic stem cell transplants that are AHCCCS covered services when medically necessary, cost effective, nonexperimental, and not primarily for purposes of research, are covered under the Health Net Access product. Live donor kidney transplants are covered for pediatric and adult members. Live donor transplants may be considered on a case-by-case basis for solid organs, other than kidney, when medically appropriate and cost effective. Detailed criteria regarding specific transplants are found under the heading *Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations* located in the Medical Policy Manual on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-DD.

Other Transplants and Devices

Following is additional information on coverage for other transplants and devices under the Health Net Access product.

- Circulatory Assist Device (CAD) is an AHCCCS covered service when used as a bridge to transplantation and other specific criteria are met, when medically necessary and prior authorized by Health Net Access. Refer to *Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations* located in the Medical Policy Manual on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-DD
- Bone grafts and corneal transplants are AHCCCS covered services, based on medical necessity and prior authorized by Health Net Access

Transportation Services

Found in: Operations Manuals > Benefits Effective 07/01/2013

Emergency Transportation Services

Found in: Operations Manuals > Benefits > Transportation Services Effective 07/01/2013

Health Net Access covers emergency ground and air ambulance transportation services within certain limitations. Covered transportation services include:

- Emergency ground and air ambulance services required to manage an emergency medical condition at an emergency scene and in transport to the nearest appropriate facility
- Maternal transport program (MTP), newborn intensive care program (NICP), basic life support (BLS), advanced life support (ALS), and air ambulance services depending upon the member's medical needs

Coverage Limitations and Exclusions

The following limitations and exclusions apply to emergency transportation services:

- Coverage of ambulance transportation is limited to those emergencies in which specially equipped transportation is required to safely manage the member's medical condition
- Emergency transportation is covered only to the nearest appropriate facility medically equipped to provide definitive medical care
- Emergency transportation to an out-of-state facility is covered only if it is to the nearest appropriate facility
- Mileage reimbursement is limited to loaded mileage. Loaded mileage is the distance traveled, measured in miles while a member is on board the ambulance and being transported to receive emergency services
- A provider who responds to an emergency call and provides medically necessary treatment at the scene, but does not transport the member is eligible for reimbursement limited to the approved base rate and medical supplies used
- A provider who responds to an emergency call, but does not treat or transport a member as a result of the call is not eligible for reimbursement
- When two or more members are transported in the same ambulance, each shall be charged an equal percentage of the base rate and mileage charges
- Air ambulance services are covered under the following conditions:
    - The point of pick-up is inaccessible by ground ambulance
    - Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities
    - The member's medical condition requires air ambulance services and ground ambulance services will not suffice

Details regarding emergency transportation services are available in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual on the AHCCCS website

at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-BB.

Nonemergency Medical Transportation Services

Found in: Operations Manuals > Benefits > Transportation Services Effective 07/01/2013

Health Net Access covers medically necessary non-emergency ground and air transportation to and from a required medical service.

Round-trip air or ground ambulance transportation services may be covered when a hospitalized member is transported to another facility for necessary specialized diagnostic and/or therapeutic services, if all of the following requirements are met:

- The member's condition is such that the use of any other method of transportation is not appropriate
- Services are not available in the hospital in which the member is an inpatient
- The hospital furnishing the services is the nearest one with such facilities
- The member returns to the point of origin

Medically necessary nonemergency transportation to and from participating Health Net Access providers is a covered service for members who are not able to arrange or pay for transportation. Transportation is limited to the cost of transporting the member to the nearest Health Net Access provider capable of meeting the member's medical needs. Transportation is only provided to transport the member to and from the required Access-covered medical service.

Details regarding nonemergency medical transportation services are available in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf, Policy 310-BB.

X-Ray and Laboratory Services

Found in: Operations Manuals > Benefits Effective 08/06/2015

Laboratory Services

Found in: Operations Manuals > Benefits > X-Ray and Laboratory Services Effective 07/01/2013

Laboratory services must be provided by a participating laboratory provider. Services provided by a non-participating provider or facility must be authorized by Health Net Access prior to the services being provided or the member is responsible for payment. Medically necessary diagnostic testing and screening are covered services.

Participating providers may offer laboratory work in their offices; however, some services are considered bundled charges and are not paid in addition to an office visit fee.

Genetic Testing Provisions

All genetic testing requires prior authorization. Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations.

- Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment option specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member
- Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future
- Routine, non-genetic testing for other medical conditions (such as renal disease and hepatic disease) that may be associated with an underlying genetic condition is covered when medically necessary
- Genetic testing is not covered as a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly
- Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases
- Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer

Radiology Services

Found in: Operations Manuals > Benefits > X-Ray and Laboratory Services Effective 07/01/2013

Health Net Access provides benefits for medically necessary radiology and medical imaging services for all eligible members when ordered by a primary care provider

(PCP) or other practitioner for diagnosis, prevention, treatment, or assessment of medical conditions.

Radiology services must be provided by a participating radiology provider. Members may be responsible for copayments that correspond to the type of facility where services are rendered.

Complete the entire radiology order form when requesting radiology services, including all insurance information.

Participating providers with applicable radiology equipment can provide diagnostic radiology services in their office.

Claims and Provider Reimbursement

Found in: Operations Manuals Effective 01/01/2003

Billing the Member

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

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

- 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's Medicare or a commercial carrier. Providers must bill Health Net for these amounts and Health Net coordinates benefits.
- AHCCCS ***mandatory*** copayments should be collected at the time of service, but may be billed to the member if payment does not occur.
- Providers may 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, have the member sign a statement that clearly states the services to be performed, the non-eligible status and the amount of the charge and agreeing to pay for the services. The document must be retained in the member's medical record.

Claim Status

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

To receive automated claim status information, contact the Health Net Access Provider Services Center interactive voice response (IVR) system. Providers can also check claims status online at www.healthnetaccess.com.

Claim Submission Timelines

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

In accordance with Arizona Revised Statutes (ARS) §36-2904 (G), claims for services provided to an Arizona Health Care Cost Containment System (AHCCCS) member must be received in a timely manner as follows:

- The initial claim must be received no later than six months from the date of service or the date of eligibility posting; whichever is later. For inpatient claims, date of service is the patient's date of discharge.
- Claims initially received after the six-month time frame, are denied.
- If a claim is originally received within the six-month time frame, the provider has up to 12 months from the date of service or date of eligibility posting (whichever is later) to resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim.
- If the claim does not achieve clean claim status or is not adjusted correctly within 12 months, Health Net Access is not liable for payment.
- This time limit does not apply to adjustments, which would decrease the original payment due to collections from Medicare or other third party payers.

Retro-Eligibility Claims

A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system for the date(s) of service, but at a later date eligibility was posted retroactively to cover the date(s) of service. Timely filing time frames are as follows:

- The initial claim must be received no later than six months from the AHCCCS date of eligibility posting.

- Retro-eligibility claims must obtain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.
- This time limit does not apply to adjustments, which would decrease the original payment due to collections from Medicare or other third party payers.

Claims Reimbursement

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Claims reimbursement is based on contractual agreements that utilize the Arizona Health Care Cost Containment System (AHCCCS) pricing methodologies. These are inclusive of, but are not limited to:

- All patient refined diagnosis related group (APR-DRG)
- Tiered per diem payment structure.
- Outpatient Hospital Fee Schedule (OPFS) for outpatient facilities.
- AHCCCS fee schedules and negotiated rates.
- Arizona Department of Health Services (ADHS) rates.

Claims Submission Requirements

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 07/01/2016

Health Net participating providers are required to submit claims for all services that are provided to Health Net Access members.

Submit claims to the Health Net Access Claims Submission address using the most current CMS-1500 or CMS-1450 (UB-04) form. Claim forms must be printed in Flint OCR Red, J6983, or exact match ink. Health Net Access no longer accepts handwritten red and black forms or copied claim forms.

Although a copy of the CMS-1500 and CMS-1450 form can be downloaded, copies of the form cannot be used for submission of claims, since a copy may not accurately replicate the scale and OCR color of the form. Paper claims received by the plan are scanned using OCR technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. Photocopies cannot be scanned and, therefore, are no longer accepted by Health Net Access.

CMS-1500 and CMS-1450 completion and coding instructions, as well as the print specifications are available in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04).

The following information must be included on the claim:

CMS-1500 Claim Form

- Arizona Health Care Cost Containment System (AHCCCS) identification (ID) number (paper claims only)
- member's name, gender and date of birth
- diagnosis code number (ICD-10) - enter at least one ICD-10 diagnosis code to describe the member's condition. Up to 12 ICD-10 codes may be entered. The codes must be entered in the A, B, C format order indicated on the claim form. Behavioral health providers must not use DSM-4 or DSM-5 diagnosis codes
- Medicaid resubmission code (box 22 on the CMS-1500), if applicable - enter the appropriate code (7 to indicate a replaced or corrected claim or 8 to indicate a void of a previous claim), along with the applicable claim identification number
- date(s) of service - enter the beginning and ending service dates
- place of service
- emergency indicator, if applicable - enter a check mark, X or Y if the service was an emergency service
- procedures, services and supplies - enter the CPT or HCPCS procedure code that identifies the service provided
- diagnosis code pointer
- billed amount for each service line
- service units
- rendering provider NPI (box 24J)
- billing provider tax ID number
- patient account number, if applicable
- total charges for the claim
- amount previously paid, if applicable - enter the total payment amount the provider received for this claim from all sources other than Health Net Access
- signature and date - the provider or his or her representative must sign and date the claim
- service facility location information, NPI and AHCCCS ID number, if applicable
- billing provider's name, address, telephone number, and NPI

UB-04 Claim Form

- name, address and telephone number of the provider rendering service
- patient control number, if applicable
- bill type
- facility's federal tax ID number
- statement covers period - enter the beginning and ending dates of the billing period
- patient name, address, date of birth and gender
- admission/start of care date
- admission hour, if applicable
- type of admission
- point of origin for admission or visit
- discharge hour
- patient discharge status
- condition codes, if applicable
- occurrence codes, if applicable
- responsible party name and address, if applicable
- value codes and amounts, if applicable
- revenue code(s)
- revenue code description/NDC code, if applicable
- HCPCS/rates - enter the inpatient accommodation rate and the appropriate CPT or HCPCS code
- service date and service units
- total charges for each revenue code
- non-covered charges, if applicable
- payer - enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred
- billing provider's NPI
- diagnosis and procedure code qualifier
- principle diagnosis code, admitting diagnosis code
- other diagnosis codes, if applicable
- principle procedure code and dates, if applicable
- attending provider name and identifiers, if applicable
- operating physician and identifiers, if applicable
- other procedure codes, if applicable

Detailed instructions on how to fill out the claim forms can be found on the AHCCCS website.

Clean Claim Submission Guidelines

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

As defined by Arizona Revised Statutes (ARS) §36-2904 (G)(1) a "clean claim" is a claim that may 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.
- The claim meets all Arizona Health Care Cost Containment System (AHCCCS) submission requirements.
- The only acceptable claim forms are those printed in Flint OCR Red, J6983 or exact match ink.
- 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.
- Non-covered services.
- Provider of service is not registered with AHCCCS on the date of service.
- Information from the primary carrier is required.

Corrected Claims Submission

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Providers must correct and resubmit claims to Health Net 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 resubmission indicator (7 for replacement or 8 to void a prior claim) must be indicated in Box 22 along with the original claim reference number from the remittance advice (RA) must be included on the claim in order for Health Net 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.

Electronic Claim Submission

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Health Net contracts with Capario, Change Health Care (formerly Emdeon (WebMD)) and Ability Network (formerly MD On-Line) to provide claims clearinghouse services for Health Net electronic claim submission.

The benefits of electronic claim submission includes:

- Reduction and elimination of costs associated with printing and mailing paper claims
- Improvement of data integrity through the use of clearinghouse edits
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment
- Confirmation of receipt of claims by the clearinghouse
- Availability of reports when electronic claims are rejected and ability to track electronic claims, resulting in greater accountability

Clearinghouse	**Health Net Payer Identification (ID) Number**
Capario	38309
Change Health Care	38309
As a result of Health Net's partnership with Ability Network, all payer claims can be submitted electronically via Health Net's website at provider.healthnet.com.	
Ability Network	38309

Reports

For successful electronic data interchange (EDI) claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Acceptance/rejection reports from EDI vendor
- Acceptance/rejection reports from EDI clearinghouse
- Acceptance/rejection reports from Health Net

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

Providers may also check the status of paper and electronic claims online at provider.healthnetaccess.com.

For questions regarding electronic claims submission, contact the Health Net EDI Claims Department .

Filing a Claim

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Health Net Access encourages the electronic filing of claims whenever possible. When submitting claims, it is important to accurately provide all required information as described in Claim Submission Requirements. Claims submitted with missing data may result in a delay in processing or a denial of the claim. Health Net requires that all facility claims be submitted on a UB-04 claim form. Professional fees must be submitted on an original (red) CMS-1500 claim form. Copies of claim forms are not accepted. Participating providers receive a Remittance Advice (RA) each time a claim is processed.

When Health Net Access is the primary payer, claims must be submitted no later than six months from the date of service or the date of eligibility posting (whichever is later). For inpatient hospital claims, the date of service is considered to be the date of discharge. Initial 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. Following the initial claim submission, Health Net Access allows submission of the secondary claim for up to one year from the primary EOB date. The submission must include the primary carrier's EOB.

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

Acceptable proof of timely filing includes:

- EOB from another insurance carrier dated within Health Net's timely filing limits.
- Denial letter from another insurance carrier, printed on its letterhead and dated within Health Net's timely filing limits.
- Electronic data interchange (EDI) rejection report from clearinghouse which indicates claim was forwarded and accepted by Health Net (showing date received versus date of service) that reflects the claim was submitted within Health Net's 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.
- Billing ledger.
- 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.

Health Net Access Interest Calculation

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 10/04/2016

The following information applies to interest rate calculations and turnaround times for Medicaid claims.

Non-Hospital Claims

Interest is due on payment for clean claims not reimbursed within the required turn-around time. The interest period begins on the day after payment is due and ends on the date of payment. Interest is prorated on a daily basis at a rate of 10percent per annum unless otherwise indicated contractually. It is calculated based on the difference between the date of claim receipt and the date of payment. Interest is not paid on claims for which no payment is due or claims that are fully denied.

Claims Payment Standards

Health Net Access insures that 95 percent of all clean claims are adjudicated within 30 calendar days of receipt of the clean claim, and 99 percent are adjudicated within 60 calendar days of receipt of the clean claim.

Hospital Claims

Turnaround Times

Hospital claims for participating and non-participating providers must be paid or denied within 60 calendar days.

Interest

For outpatient and inpatient acute care hospital clean claims, Health Net applies quick pay discounts and slow payment penalties for participating and non-participating providers in accordance with Arizona Health Care Cost Containment System (AHCCCS) guidelines. A quick pay discount is applied to hospital claims with AHCCCS provider type 02 and C4 at a rate of one percent when a claim is paid within 30 calendar days of the clean claim receipt date. A slow payment penalty is applied for claims paid at 61 days or over, and continues to accrue at the rate of one percent per month (based on a 30 calendar-day month) or partial month until the claim is paid. The calculation is determined based on the difference between the claim receipt date and the date of payment.

Clean claims for a skilled nursing facility that is not paid within 30 calendar days after the claim is received accrues interest at the rate of one percent per month from the date the claim is submitted. The interest is prorated on a daily basis and must be paid at the time the clean claim is paid.

Obstetrical Services

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

The global obstetrical (OB) package includes all antepartum visits, delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.

- Only services not included in the global OB care CPT code (59400 or 59510) may be billed separately.
- While there is not a separate reimbursement for the evaluation and management services that are provided during the prenatal and postpartum care periods, AHCCCS requires that the codes and individual dates of services be included in the global OB service billing.
- Claims for ineligible services are denied when billed in addition to the global OB code.

Services not included in the global OB package and may be billed separately include:

- amniocentesis
- ultrasound
- special screening tests for genetic conditions
- visits for unrelated conditions

Refer to the *Maternity Care and Delivery* section of the CPT code book for details regarding the appropriate coding to use for obstetrical services.

Overpayment Recovery Procedures

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

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

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

- Send a check made payable to the appropriate entity (Health Net of Arizona, Inc. or Health Net Life Insurance Company)
- Include a copy of the RA that accompanied the overpayment to expedite Health Net Access' adjustment of the provider's account. 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 identification (ID) number, vendor name, provider tax ID number, provider number, vendor number, and reason for the overpayment refund. If the RA is not available, it takes longer for Health Net Access to process the overpayment refund
- Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department. If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net Access, the provider must 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 the provider has not cashed the check, he or she should return the check to the Health Net Overpayment Recovery Department with the applicable RA and a cover letter indicating why the check is being returned.

Prior Period Coverage

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Prior period coverage refers to the time frame from the effective date of eligibility to the day the member is enrolled with Health Net Access. Health Net Access is responsible for payment of all claims for medically necessary covered services, including behavioral health services provided on or after October 1, 2015 to dual-eligible members with General Mental Health/Substance Abuse (GMH/SA) needs, during prior period coverage.

Professional Claim Editing

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Health Net Access claim processing includes programs that support editing related to National Correct Coding Initiatives (NCCI), bundling/unbundling, multiple procedure/surgical reductions and global E&M bundling standards. The source logic is obtained through various resources such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA) and other specialty academies. Health Net Access has the ability to apply advanced contextual processing for application of Health Net Access edit logic.

Remittance Advice

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Health Net Access' remittance advice (RA) contains important information about claims submissions and cash receipts for overpayments. The RA should be reviewed upon receipt and reconciled against billing records. The RA includes Health Net member names and dollar amounts paid for all claims processed during the course of a week. Processing claims and adjustments results in one of the following remittance situations:

- **Positive remittance -** A remittance that totals to a positive amount and results in a payment to the provider. The total at the bottom of the RA agrees with the check or electronic payment the provider receives.
- **Negative remittance -** A remittance produced when the adjusted dollars exceed the total amount of payment on the remittance. The total at the bottom of the RA is

negative, and does not result in a check or electronic payment to the provider.

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.

Providers are encouraged to register to receive Health Net Access' electronic RA (ERA) and electronic funds transfer (EFT). Providers must submit a registration form to Health Net Access along with a registration form to one of the approved clearinghouses.

To register for ERA or EFT, contact the Health Net EDI Department.

Specific Billing Requirements

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

The following are billing requirements for specific services and procedures.

Anesthesia - Anesthesia services (except epidurals) require the continuous physical presence of the anesthesiologist or certified 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 the appropriate modifiers to reflect the assistant surgeon provider type (80/AS) as well as any services subject to multiple surgery guidelines.

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/AS for assistant surgeon**,** modifier 62 for co-surgeons and modifier 66 for surgical team**.**

Newborn Billing - Health Net's Newborn Data Collection Unit must be notified of all newborn admissions. Identification of the admitting pediatrician must be provided when calling in the notification. Notification must be given no later than three days after the birth in order to ensure proper enrollment of the newborn with the Arizona Health Care Cost Containment System (AHCCCS) and Health Net Access.

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 identification (ID) numbers, and services for a newborn must be billed separately using the newborn's ID number.

Vaccines for Children Program Billing Procedures

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 09/28/2016

Arizona Health Care Cost Containment System (AHCCCS) providers who have registered for the Vaccines for Children (VFC) program must submit claims to Health Net Access for the VFC program supplied immunizations in order to receive reimbursement for the administration. The vaccines must be on the VFC listing and must be billed as follows:

For each immunization administered, the claim must include:

- Vaccine CPT code with the modifier SL (indicating a state-supplied vaccine)
  - No charge
- Applicable administration CPT code with the modifier SL (indicating a state supplied vaccine) and unit value equal to the code description and number of vaccines provided.
  - Usual and customary charge

Providers must submit administration and vaccine codes on one claim form. Multiple claims should not be submitted.

Providers submitting multiple CMS-1500 for successor forms must staple the completed forms together and number the pages appropriately.

Use of modifier SL sufficiently identifies the claim as a state-supplied vaccine for which the billed vaccine charge is not reimbursed. Using modifier SL ensures that the claim is processed, the provider is reimbursed for the administration fee and the vaccination is included in performance measurements.

These billing procedures are designed to standardize billing practices and eliminate erroneous payments for state-supplied vaccines, which necessitate collection of overpayments from providers. Health Net Access may seek reimbursement of amounts that were paid inappropriately.

Failure to bill VFC claims in accordance with the billing procedures noted above results in denials for both the vaccine and the associated administration.

Remittance Advice Sample

Found in: Operations Manuals > Claims and Provider Reimbursement Effective 07/01/2013

Claims Coding Policies

Found in: Operations Manuals Effective 01/01/2003

Basic Coding Guidelines

Found in: Operations Manuals > Claims Coding Policies Effective 09/28/2016

Current ICD-10-CM codes, CPT codes, HCPCS codes, and modifiers reflective of the date of service are required on all Health Net Access claims.

These codes should be used in basic accordance with the publishers' stated guidelines. Three major publications, the American Medical Association's (AMA) CPT-4 code book, the Centers for Medicare & Medicaid Services (CMS) HCPCS code book and the ICD-10-CM, represent the basic standard of service code documentation and reference required by Health Net.

Valid ICD-10-CM diagnosis codes are required on all claims. The first diagnosis on the claim form is reserved for the primary diagnosis. Up to four diagnoses may be reported.

Code each diagnosis to the highest level of specificity (fourth or seventh digit when available).

Valid AMA CPT-4 and Level II HCPCS procedure codes are required on all claims. A three-month grace period for submitting deleted codes is allowed. After three months, deleted codes are denied.

Procedure codes should be chosen based on the publishers' definitions and be appropriate for the age and gender of the patient.

Procedure code modifiers are to be used only when the service meets the definition of the modifier and are to be linked only to procedure codes intended for their use.

If a deleted code and its current replacement code are submitted on the same date of service, the last code submitted is denied as a duplicate.

Health Net Access does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- AMA CPT code book
- CMS national policy
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Global Surgery

Found in: Operations Manuals > Claims Coding Policies Effective 09/28/2016

The global surgical package includes all necessary services normally provided by the surgeon before, during and after the surgical procedure. The global surgical package applies to minor procedures that have a zero or 10-day post-operative period and major procedures that have a 90-day post-operative period as defined by the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule. It also applies to obstetrical procedures that have a 42-day post-operative period.

The global surgical package policy applies to all places of service.

Services Included in the Global Package

The following services are included in the global surgical package and, therefore, are not eligible for separate payment:

- Preoperative evaluation and management (E&M) services that are performed one day prior to major surgery or on the same day as a minor or major procedure.
    - Exception: New patient visits (CPT codes 99201-99205) on the same day as a minor surgery are not included in the global package.
- Intraoperative services that are a usual and necessary part of the surgical procedure.
- Anesthesia provided by the surgeon.
- Supplies.
- All additional medical or surgical services required of the surgeon during the post-operative period because of complications, which do not require additional trips to the operating room.
- Post-operative E&M services that are related to the surgery.
- Post-operative pain management by the surgeon.
- Dressing changes, local incision care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and change and removal of tracheostomy tubes.

Services Not Included in the Global Surgery Package

The following services are not included in the global surgical package and are eligible for separate payment:

- E&M service that was significant and separately identifiable from the minor surgical procedure performed on the same day. Modifier -25 should be added to the E&M code.
- E&M service performed the day prior to or on the same day of surgery that resulted in the decision for a major surgical procedure. Modifier -57 should be added to the E&M code.
- E&M services that occur during the post-operative period that are unrelated to the surgery. Modifier -24 should be added to the E&M code.
- Critical care when billed for serious injuries or burns.
- Services of other physicians not in the same provider group of the physician that performed the surgery, except where a formal transfer of care occurs.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Clearly distinct surgical procedures during the post-operative period that are not re-operations or treatment for complications. Modifiers -58 (staged procedure) or -79 (unrelated procedure or service performed by a physician during the post-operative period) should be added to the surgical procedure code.
- Treatment of post-operative complications that require a trip to the operating room. Modifier -78 should be added to the surgical procedure code.
- Immunosuppressive therapy for organ transplants. Modifier -24 should be added to the E&M code.

Note: An E&M service that was significant and separately identifiable from the minor surgical procedure performed on the same day that falls within a global period of a previous service but is not related to the previous service requires both a modifier -25 and a modifier -24.

Health Net Access does not require documentation at the time of claim submission unless the service is listed as by report; however, in the event the claim is audited, documentation may be required.

Supporting Sources

CMS national policy

Multiple Procedure Reduction

Found in: Operations Manuals > Claims Coding Policies Effective 09/28/2016

When multiple procedures are performed by the same provider at the same session, they are typically subject to the multiple procedure reduction. The primary procedure code is reported as listed and is reimbursed at the full allowed amount. The additional procedure code(s) is reported with a modifier -51 and is reimbursed at a reduced amount. Add-on codes and American Medical Association (AMA) CPT modifier -51 exempt codes should not be reported with modifier -51 as they are excluded from multiple procedure reduction.

Health Net Access applies the multiple procedure reduction to the list of codes on the Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule that are subject to multiple surgery guidelines with the exception of the AMA CPT modifier -51 exempt codes on the list. These codes are not subject to multiple procedure reduction. Final adjudication is based on information presented in the Arizona Health Care Cost Containment System (AHCCCS) reference files. If there is a conflict, the AHCCCS reference files will be the guideline utilized, but a request for review can be initiated with supporting documentation.

Health Net Access reimburses multiple procedures using a 100 percent, 50 percent, 50 percent methodology. The procedure with the highest reimbursement value is paid at 100 percent of the allowed amount. Subsequent procedures are paid at 50 percent of the allowed amount.

All procedures should be billed together on one claim to avoid subsequent retractions and adjustments that may occur when procedures are billed separately.

Health Net Access does not require documentation at the time of claim submission other than for by report procedures; however, if the claim is audited, documentation may be required.

Supporting Sources

- CMS national policy
- AMA CPT code book
- AHCCCS reference files

Professional Claim Editing

Found in: Operations Manuals > Claims Coding Policies Effective 09/28/2016

Health Net Access utilizes several sources to validate professional claim editing and associated policies. Health Net Access has the ability to apply advanced contextual processing for application of Health Net edit logic.

Provider Preventable Conditions

Found in: Operations Manuals > Claims Coding Policies Effective 09/28/2016

Section 2702 of the Patient Protection and Affordable Care Act reduces or prohibits payments to health care providers for Medicaid services rendered as a result of certain preventable health care acquired illnesses or injuries. Health Net Access processes medical claims utilizing the list of provider preventable conditions (PPCs) and surgical errors and reduces or prohibits payments for PPCs.

The Centers for Medicare & Medicaid Services (CMS) issued a final rule implementing section 2702, which reduces or prohibits payments related to PPCs. This rule was built on Medicare's strategies that already reduce or prohibit hospital payments for preventable conditions, and also improved alignment between Medicare and Medicaid payment policies. Although the new rule gives states the flexibility to expand the list of other provider preventable conditions (OPPCs), Arizona currently employs only the Medicare National Coverage Determinations (NCDs) list as described in the Other Provider-Preventable Conditions definition below.

Definitions

PPCs are defined as either of the following:

- Health Care-Acquired Condition (HCAC) - Applies only to Medicaid inpatient hospital settings and are included in the following Medicare list of hospital-acquired conditions (HACs):

- Retained foreign object following surgical procedures.
- Air embolism.
- Blood incompatibility.
- Stage III and IV pressure ulcers.
- Injuries resulting from falls and trauma.
- Catheter-associated urinary tract infections.
- Vascular catheter-associated infections.
- Manifestations for poor glycemic control.
- Mediastinitis following coronary artery bypass graft (CABG) procedures.
- Surgical site infections following orthopedic surgery procedures involving spinal column fusion or re-fusion, arthrodesis of the shoulder or elbow, or other procedures on the shoulder or elbow.
- Surgical site infections following bariatric surgery procedures.
- Deep vein thrombosis or pulmonary embolism following total hip or knee procedures, except in pediatric or obstetrical patients.

- Other Provider-Preventable Condition (OPPC) - Applies to Medicaid inpatient or outpatient health care settings and includes any of the three Medicare NCDs:
  - Surgery on the wrong patient.
  - Wrong surgery on a patient.
  - Surgery on the wrong site.

Reporting Requirements

Health Net Access requires providers to both report to the proper Arizona authorities and to Health Net Access incidents of abuse, neglect, as well as any injury (such as falls and fractures), exploitation, HCAC, and/or unexpected death as soon as the providers are aware of the incident. In turn, Health Net Access reports all incidents of abuse, neglect, injury, exploitation, HCAC, and unexpected deaths to the Arizona Health Care Cost Containment System (AHCCCS) Clinical Quality Management Unit.

Reporting to Health Net Access

- Potential Quality Issue (PQI) Referral Form - Providers must complete a Health Net Access PQI referral form to report all incidents of abuse, neglect, as well as any injury (such as falls and fractures), exploitation, HCAC, and/or unexpected death as soon as the provider is aware of the incident. Submit the completed form directly via secure fax to Health Net Access at 1-877-808-7024 within one business day of the event or occurrence
- Claim forms (UB-04 and CMS-1500) - Under the federal rule implementing Section 2702, providers must report the occurrence of any PPC in a Health Net Access member, regardless of whether the provider has submitted a claim for payment for the services that resulted in the PPC. Providers should report these occurrences through the use of the appropriate codes on the UB-04 claim form for facility services or the CMS-1500 claim form for professional services

Codes

HCACs use diagnosis codes E870-E876.9 as well as CMS HAC codes. Unlike HCACs, OPPCs are not confined to conditions occurring in the inpatient hospital setting, but may occur in either the inpatient or outpatient setting. In this case, outpatient is not limited to hospital outpatient departments, but may include other outpatient settings, such as a clinic, ambulatory surgical center (ASC), federally qualified health center (FQHC), or physician's office. Health Net Access utilizes the following modifiers to define conditions considered to by OPPCs:

- PA - Surgery wrong body part
- PB - Surgery wrong patient
- PC - Wrong surgery on patient

Compliance and Regulations

Found in: Operations Manuals Effective 01/01/2003

Federal Lobbying Restrictions

Found in: Operations Manuals > Compliance and Regulations Effective 12/18/2012

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

- File a declaration with Health Net certifying that no inappropriate use of federal funds has occurred or will occur (use Certification for Contracts, Grants, Loans, and Cooperative Agreements Form). This extends to any subcontract a participating provider

may have that exceeds $100,000 in value. In these cases, the participating provider is required to collect and retain these declarations
- File a specific disclosure form if non-federal funds have been used for lobbying purposes in connection with any Health Net line of business (use Disclosure of Lobbying Activities Form and Disclosure Form Instructions)
- File quarterly updates, such as a disclosure form at the end of any calendar quarter in which disclosure is required or in which an event occurs that materially affects the previously filed disclosure form

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

Participating providers who complete the Certification for Contracts, Grants, Loans, and Cooperative Agreements Form should send it directly to their assigned Health Net provider network representative.

Health Net participating providers are required to comply with applicable state laws and regulations and Health Net policies and procedures. The contents of Health Net's operations manuals are supplemental to the *PPA* and its addendums. When the contents of Health Net's operations manuals conflict with the *PPA*, the *PPA* takes precedence.

Provider Right to Advocate on Members' Behalf

Found in: Operations Manuals > Compliance and Regulations Effective 11/11/2014

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 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

Contracting

Found in: Operations Manuals Effective 01/01/2003

Modifications

Found in: Operations Manuals > Contracting Effective 06/28/2016

A request to add new providers to an existing *Provider Participation Agreement* (*PPA*) requires completion of the AzAHP Practitioner Data Form for physicians or AzAHP Organizational Data Form for other provider types. New physicians are not permitted to treat Health Net members until all credentialing requirements have been met and the physician has been formally added to the *PPA.*

Note: Providers must include their National Provider Identifier (NPI) on the Provider Participation Request form they submit to Health Net. Providers participating in Health Net Access must include the Arizona Health Care Cost Containment System (AHCCCS) identification number and NPI. Any subsequent changes to either the AHCCCS identification (ID) number or NPI require completion and submission of a Demographic Update form, as described below.

Any changes to demographic information for physicians, clinicians or other entities listed as participating providers on an existing *PPA* require completion of the Demographic Update form. Demographic changes include:

- Name changes.
- Tax ID numbers or changes or additions of AHCCCS ID numbers.
- Primary address and billing address changes.
- Addition or deletion of locations.
- Provider termination notifications.
- Specialty or sub-specialty changes.

When changing a tax ID number, include a new W-9 and the effective date. Participating providers may be held responsible for Internal Revenue Service (IRS) fines imposed by Health

Net associated with incorrect tax IDs if the provider fails to notify Health Net in writing prior to the change. Health Net is unable to change tax IDs retroactively.

Changes must be submitted in writing to the Health Net Provider Network Management Department 60 days prior to the change or as soon as reasonably possible.

Health Net must approve any new or modified subcontracts prior to the effective date. Submit a copy of the proposed agreement to the Health Net Provider Network Management Department.

Provider Online Demographic Data Verification

Physicians, hospitals, ancillary providers, and medical groups or IPAs are required to provide advance notification to Health Net or their medical groups or IPAs with changes to their demographic information. On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website under ProviderSearch.

Demographic Information

Providers' demographic data information should include the following:

- name
- address
- telephone number
- fax number
- office hours
- languages other than English spoken by the physician
- handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/scale (T) - if accessibility is not yes to all, then indicate no

Notification and Maintenance Requirements

Providers directly contracting with Health Net must notify Health Net of changes by completing the online form, which is available on the provider website under Manage My Account > Account Management Tools > Update Provider Information.

Providers contracting through a medical group or IPA must notify the medical group or IPA directly of changes, and the medical group or IPA notifies Health Net. Medical groups or IPAs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net on a real-time basis. Real-time is within 30 days, as defined by the Centers for Medicare & Medicaid Services (CMS).

Requesting Participation in the Health Net Network

Found in: Operations Manuals > Contracting Effective 05/13/2014

Providers who are interested in participating in the Health Net network must submit a completed AzAHP Practitioner Data Form for physicians or AzAHP Organizational Data Form for other provider types. Mail or fax the completed form to the Health Net Provider Network Management Department. A provider network representative will contact your office via telephone or mail.

Terminations

Found in: Operations Manuals > Contracting Effective 06/01/2009

Participating providers terminating a physician, clinician or other entity from an existing *Provider Participation Agreement* (*PPA*) must submit the following information:

- Physician's full name
- Specialty type (or entity type if facility or ancillary)
- License number
- Practice location
- Effective date of the change
- Covering physician
- Contact name, address and telephone number

This information must be submitted in writing to the Health Net Provider Network Management Department at least 60 days prior to the termination. Upon termination, Health Net may invoke a 12-month waiting period before the provider may re-apply for a contract; however, the termination clause varies based on the *PPA*..

Health Net must be notified of participating providers who terminate a subcontract. This information must be submitted in writing to the Health Net Provider Network Management Department at least 60 days prior to the termination.

Coordination of Benefits

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Coordination of Benefits Effective 07/01/2013

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 payor 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.

COB Payment Calculations

Found in: Operations Manuals > Coordination of Benefits Effective 07/01/2013

As the secondary carrier, Health Net 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.

Providing COB Information

Found in: Operations Manuals > Coordination of Benefits Effective 10/01/2014

In order for Health Net to document member records and process claims appropriately, include the following information on all coordination of benefits (COB) claims:

- Name of the other carrier
- Subscriber identification (ID) number with the other carrier

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

- First, file the claim with the other carrier
- After the primary carrier has paid, attach a copy of the Explanation of Payment (EOP) or Explanation of Benefits (EOB) to a copy of the claim and submit both to Health Net 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 prior to the timely filing limit of six months from the date of service. Health Net 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.

Copayments

Found in: Operations Manuals Effective 01/01/2003

Copayment Requirements

Found in: Operations Manuals > Copayments Effective 07/01/2013

Copayment Requirements

Members eligible for Health Net Access through the Transitional Medical Assistance (TMA) and Childless Adults/Title XIX Waiver Group (TWG) programs may be subject to mandatory copayments when receiving covered services. Providers may deny services to members who do not pay applicable copayments. However, certain services (such as emergency services) and specific populations (such as members under the age of 19) are exempt from mandatory copayments.

Copayments are never charged for the following:

- Hospitalizations
- Emergency services

- Family planning services and supplies
- Pregnancy-related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women

Copayment Levels

Members are assigned a copayment level, which indicates whether they are exempt from copayments or subject to copayments. Providers can locate a member's copayment level on the first page of the member's eligibility screen on the Arizona Health Care Cost Containment System (AHCCCS) website at https://azweb.statemedicaid.us/home.asp.

Credentialing

Found in: Operations Manuals Effective 01/01/2003

Application Process

Found in: Operations Manuals > Credentialing Effective 07/01/2013

Practitioners or organizational providers subject to credentialing and recredentialing, and contracting directly with Health Net, must provide a completed application to the specified vendor. By submitting a completed application, the practitioner or provider:

- Affirms the comprehensiveness and truthfulness of representations made in the application, including lack of present and illegal drug use
- Indicates a willingness to provide additional information required for the credentialing process
- Authorizes Health Net to obtain information regarding the applicant's qualifications, competence or other information relevant to the credentialing review
- Releases Health Net and its independent contractors, agents and employees from any liability connected with the credentialing review

Health Net does not discriminate in terms of participation, reimbursement or indemnification against any health care practitioner or provider acting within the scope of licensure and certification under federal or state law. Assurance of nondiscrimination is met by using standardized credentialing criteria.

All Health Net Credentialing Committee members sign confidentiality/conflict of interest statements attesting to adherence to Health Net's non-discriminatory credentialing practices. Cases reviewed by the Credentialing Committee are blinded and tracking and trending practices monitor reasons for network denial or termination.

Approval, Denial or Termination of Credentialing Status

Found in: Operations Manuals > Credentialing Effective 07/01/2013

Each month, or more frequently as dictated by business needs, the Health Net Credentialing Committee or medical director committee chair reviews rosters of delegated and nondelegated practitioners and organizational providers meeting all Health Net standards for participation and approves admittance or continued participation in the Health Net network. The Credentialing Committee also reviews and accepts rosters of practitioners and providers that do not meet credentialing or recredentialing criteria for administrative reasons, such as expired license, inadequate malpractice insurance coverage or incomplete work history. Practitioners and providers who fail to respond to requests for a completed recredentialing application are administratively terminated from the Health Net network.

Practitioners and providers who have been administratively denied or terminated from network participation are eligible to reapply as soon as the administrative matter is resolved.

Network applicants are notified in writing of the Credentialing Committee's participation decision within 180 days of Health Net's receipt of a completed application. Temporary or provisional credentialing is completed no more than 14 calendar days from receipt of a completed application packet.

The Credentialing Committee follows a peer-review process for practitioners and providers with a history of adverse actions, member complaints, negative quality improvement (QI) activities, impaired health, substance abuse, health care fraud and abuse, criminal history, or similar conditions to determine whether a practitioner should be admitted or retained in the Health Net network. If a network denial or termination decision is based on health status, quality of care or disciplinary action, the practitioner or provider is afforded appeal rights.

All committee decisions regarding approval, denial, limitation, suspension, or termination of credentialing status are communicated in writing in a manner that is consistent with health plan, state and federal regulatory requirements, and accrediting entity standards. Such notice, when applicable, includes information regarding the reasons for denial or termination.

Credentialing Responsibility, Oversight and Delegation

Found in: Operations Manuals > Credentialing Effective 06/01/2009

Health Net may delegate to individual practitioners or medical groups the responsibility for activities associated with credentialing and recredentialing. Credentialing procedures used by these entities may vary from Health Net procedures, but must be consistent with health plan, state and federal regulatory requirements and accrediting entity standards.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the oversight of delegated activities must meet or exceed Health Net standards. Health Net oversees delegated responsibilities on an ongoing basis through an annual audit and semi-annual, or more frequent, review of delegated group-specific data.

Health Net can revoke the delegation of any or all credentialing activities if the delegated medical group or entity is deemed noncompliant with established credentialing standards. Health Net retains the right, based on quality issues, to terminate or restrict the practice of individual practitioners, providers and sites, regardless of the credentialing delegation status of the group.

Each delegated practitioner or provider losing delegated credentialing status must complete Health Net's initial credentialing process within six months.

Health Net Standards of Participation

Found in: Operations Manuals > Credentialing Effective 07/01/2013

All practitioners participating in Health Net's network must comply with the following Health Net standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing and practitioners due for recredentialing must complete all items on an approved credentialing application and supply supporting documentation, if required. The verification time limit for a Health Net-approved application is 180 days. All practitioner applications are completed and accessed via the Council for Affordable Quality Healthcare (CAQH) website by selecting the Universal Credentialing DataSource link. Supporting documentation includes:

- Current, unencumbered state medical license
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state
- Continuous work history for the previous five years with a written explanation of any gaps of more than six months (initial credentialing only)
- Evidence of adequate education and training for the services the practitioner is contracting or contracted to provide
- Board certification status (physicians only)
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one Health Net participating hospital or surgery center. A documented coverage arrangement with a Health Net credentialed/contracting practitioner of a like specialty or participating hospitalist group meets this requirement
- Malpractice insurance coverage that meets Health Net standards
- Answers to all confidential questions and explanations provided in writing for any question answered adversely

Additionally, the practitioner must be absent from:

- The Medicare/Medicaid Cumulative Sanction Report
- The Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE)
- General Services Administration (GSA) Excluded Parties List System (EPLS)

Only licensed, qualified applicants meeting these standards and participation requirements are accepted or retained in the Health Net network.

Hiring Non-Participating Provider

Found in: Operations Manuals > Credentialing Effective 11/06/2013

In an effort to comply with applicable federal and state laws and regulations, all participating providers in Health Net's network must comply with the following Health Net standards when hiring a non-participating provider to provide services to Health Net members. Health Net's participating providers must be able to demonstrate that each non-participating provider has supporting documentation that includes:

- Current, unencumbered state medical license
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable
- Evidence of adequate education and training for the services the practitioner is contracting to provide
- Malpractice insurance coverage through his or her own practice or through the hiring Health Net-participating provider
- Absent of any sanctions that would not allow them to see a Medicare member

Additionally, the practitioner must be absent from:

- The Medicare Opt Out report if treating Medicare members
- The Office of the Inspector General's (OIG) sanctions list of individuals and entities (LEIE) if treating Medicaid and Medicare members
- The System for Award Management's Exclusions Extract Data Package (EEDP) if treating Medicare members
- The Federal Employee Health Benefits Program Debarment Report if treating federal members

Health Net's participating providers are responsible for ongoing monitoring of sanctions and validating licensing. All Health Net participating providers are required to comply with applicable federal, state and local laws and regulations as well as Health Net policies and procedures as outlined in the *Provider Participation Agreement (PPA)*.

Investigations

Found in: Operations Manuals > Credentialing Effective 06/01/2009

Health Net investigates adverse activities indicated in a practitioner's or provider's initial credentialing or recredentialing application materials or as identified between credentialing cycles. Health Net may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. Health Net may require a practitioner or provider to supply additional information regarding any such adverse activities. Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board
- Current or past chemical dependency or substance abuse
- Health care fraud or abuse
- Member complaints
- Substantiated quality of care concerns
- Impaired health
- Criminal history
- Office of Inspector General (OIG) Medicare/Medicaid sanctions
- Federal Employees Health Benefits Program (FEHBP) debarment
- Substantiated media events
- Trended data

At Health Net's request, a practitioner or provider must assist Health Net in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within prescribed time frames.

Organizational Providers

Found in: Operations Manuals > Credentialing Effective 07/01/2013

An organizational provider (OP) is an institutional provider of health care services that is licensed by the state or otherwise authorized to operate as a health care facility. Examples of OPs include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and freestanding or and ambulatory surgical centers (FSSCs/ASCs).

Organizational providers that require credentialing and recredentialing by Health Net or its delegated entities include, but are not limited to:

- Hospitals
- Home health, hospice and home infusion providers
- SNFs
- FSSCs/ASCs, including abortion clinics
- Dialysis/end-stage renal disease (ESRD) care providers
- Laboratories
- Office-based surgery suites
- Comprehensive outpatient rehabilitation facilities
- Physical therapy and speech pathology providers
- Portable X-ray suppliers
- Radiology/imaging centers
- Behavioral health facilities (inpatient, residential and ambulatory)
- Sleep study centers
- Urgent care centers
- Federally qualified health centers and rural health clinics
- Outpatient self-management training providers
- Other providers, as deemed necessary

Providers contracting directly with Health Net must submit a completed, signed Health Net-approved organizational provider credentialing application and supporting documentation to

Health Net's contracting vendor for processing. The documentation, at a minimum, includes:

- Evidence that the provider has met all state and federal licensing and regulatory requirements
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent Centers for Medicare and Medicaid Services (CMS) certification or state licensure review/audit may be substituted. Health Net obtains a copy of each provider's site survey report and ensures each provider has received a favorable rating. This may include a completed corrective action plan (CAP) and CAP acceptance letter. A favorable site review consists of compliance with quality of care standards established by CMS or the applicable state health department
- Professional and general liability insurance coverage that meets Health Net requirements
- Overview of the facility's quality assurance and quality improvement program upon request

Organizational providers are recredentialed at least every 36 months to ensure each entity has maintained prescribed eligibility requirements. Arizona network urgent care centers are recredentialed within 24 months.

Practitioner Rights

Found in: Operations Manuals > Credentialing Effective 06/01/2011

Right of Review and Request for Current Network Status

A practitioner has the right to review information obtained by Health Net for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (for example, malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank (NPDB)/Healthcare Integrity Protection Data Bank (HIPDB)), but does not extend to review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to Health Net's credentialing manager or supervisor. The manager or supervisor of credentialing notifies the practitioner within 72 hours of the date and time when such information is available for review at Health Net's Credentialing Department. Upon written request, the Credentialing Department provides details of the practitioner's current status in the initial credentialing or recredentialing process.

Practitioners are notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board-certification expiration when one or more of these examples have not been self-reported by the practitioner on his or her application. Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

A practitioner who believes erroneous information has been supplied to Health Net by primary sources may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed explanation to the Credentialing Department manager or supervisor. Notification to Health Net must occur within 48 hours of Health Net's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his or her credentials file. Upon receipt of notification from the practitioner, Health Net re-verifies the primary source information in dispute. If the primary source information has changed, a correction is made immediately to the practitioner's credentials file. The practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to Health Net's Credentialing Department via letter or fax within 10 business days. The Credentialing Department re-verifies the primary source information if such documentation is provided. If after 10 business days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.

Primary Source Verification for Credentialing and Recredentialing

Found in: Operations Manuals > Credentialing Effective 07/01/2013

The Health Net Credentialing Department obtains and reviews information on a credentialing or recredentialing application and verifies the information in accordance with the Health Net primary source verification practices. Health Net requires medical groups/IPAs to which credentialing has been delegated to obtain primary source information (outlined below)* in accordance with Health Net standards of participation, state and federal regulatory requirements and accrediting entity standards.

Primary Source Verification Tables*

- Acupuncturist (AC)
- Audiologist (AU)
- Dentist and dental hygienist
- Doctor of chiropractic medicine (DC)
- Doctor of dental surgery (DDS)
- Doctor of medical dentistry (DMD)
- Doctor of medicine (MD)
- Doctor of naturopathic medication (ND)
- Doctor of osteopathy (DO)
- Doctor of podiatric medicine (DPM)
- Licensed clinical social worker (LCSW); marriage and family therapist (MFT); marriage, family and child counselor (MFCC); mental health counselor (MHC)
- Optometrist (OD)
- Oral and maxillofacial surgeon
- Physician assistant (PA)
- Physical therapist and occupational therapist (PT/OT)
- Psychologist (PhD, PsyD, et al.)
- Registered nurse anesthetist (RNA), nurse practitioner (NP) and certified nurse midwife (CNM)
- Speech therapist/speech pathologist (ST/SP)

Organizational Providers

- Behavioral health facilities (inpatient, residential and ambulatory)
- Comprehensive outpatient rehabilitation facilities
- Dialysis and ESRD providers
- Federally qualified health centers/rural health clinics
- Freestanding and ambulatory surgery centers
- Home health/hospice and home infusion providers
- Hospitals
- Laboratories
- Office-based surgery suites
- Outpatient self-management training providers
- Physical therapy/speech pathology providers
- Portable X-ray suppliers
- Radiology and imaging centers
- Sleep study centers
- Skilled nursing facilities (SNFs)
- Urgent care centers

Practitioner and provider types that fall within the scope of Health Net's credentialing program are subject to change at any time.

Recredentialing of Practitioners

Found in: Operations Manuals > Credentialing Effective 07/01/2013

Health Net's credentialing program establishes criteria for evaluating continuing Health Net participating practitioners. This evaluation, which includes applicable primary source verifications, is conducted in accordance with health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners meeting and maintaining Health Net standards for participation requirements are retained in the Health Net network.

Practitioners due for recredentialing must complete all items on a Council for Affordable Quality Healthcare (CAHQ) application and supply required documentation. Documentation includes, but is not limited to:

- Current state medical license
- Attestation to the ability to provide care to Health Net members without restriction
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one Health Net participating hospital or surgery center. A documented coverage arrangement with a Health Net credentialed or contracting practitioner of a like specialty or a participating hospitalist group meets this requirement
- Malpractice insurance coverage that meets Health Net standards
- Assessment of internal data, including occurrences of member complaints, quality of care trends, and other performance indicators

Site Evaluations

Found in: Operations Manuals > Credentialing Effective 07/01/2013

Health Net or its designee conducts initial site visits for primary care physician (PCP) and obstetrician/gynecologist (OB/GYN) applicants that include:

- Vaccine and medication storage regulations
- Emergency and resuscitation equipment policy
- Americans with Disabilities Act (ADA) requirements

Facility site reviews (FSRs) are also conducted to investigate member complaints relating to any practice location, regardless of practitioner specialty. This occurs when three or more complaints are received about a practice site within six months. A review of member complaint reports or related information is conducted at least every 60 days.

Events that initiate an investigation to conduct a site visit include, but are not limited to:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

When there are member complaints, a Health Net medical site coordinator or designee conduct office site evaluations using an approved Health Net site evaluation tool, which consists of the following elements:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Equipment
- Medical recordkeeping
- Other issues, including safety

If any office site visit results in an overall score below 100 percent, Health Net creates a corrective action plan (CAP) to outline deficient criteria and the actions that need to be taken by the office. Participating practitioners who refuse an office site evaluation, do not meet the CAP within a specified time frame or refuse to participate in the CAP are referred to the Health Net Credentialing Committee for administrative termination. Sites that have complied with a CAP are retained in the Health Net network.

Terminated Contracts and Reassignment of Members

Found in: Operations Manuals > Credentialing Effective 06/01/2011

Health Net notifies members as required under state and federal law if a practitioner's contract participation status is terminated. Health Net oversees reassignment of these members to another participating practitioner where appropriate.

Dispute Resolution and Appeals

Found in: Operations Manuals Effective 01/01/2003

Member Grievances and Appeals

Found in: Operations Manuals > Dispute Resolution and Appeals Effective 01/01/2003

Overview

Found in: Operations Manuals > Dispute Resolution and Appeals > Member Grievances and Appeals
Effective 06/08/2016

Health Net Access members have grievance and appeal rights mandated by Arizona law. The Arizona Health Care Cost Containment System (AHCCCS) regulates the appeal process. Health Net Access members may file appeals or grievances with Health Net Access regarding concerns they may have with the quality of care or service or in response to a denial. Health Net Access is required to respond to appeals and grievances within a very short time frame; therefore, when Health Net Access requests medical records, providers must respond promptly.

An appeal is a request for review of an action that in most cases resulted in Health Net Access sending a Notice of Action letter to the member. This could be a denial for a prior authorization request or for a claim payment or reimbursement request that has been denied. Appeals may be filed up to 60 calendar days from the date Health Net Access sent the Notice of Action letter to the member.

A grievance is filed when the member is not satisfied with the quality of care or service he or she has received. There is no time limit for a member to file a grievance.

A member's authorized representative or provider acting on behalf of the member can initiate an appeal or grievance by calling the Health Net Access Provider Services Center or by mailing or faxing the information to the Health Net Access Member Appeals and Grievances Department.

Participating providers may be asked to provide information needed for Health Net Access to reach a timely resolution of a grievance or appeal initiated by a member. Providers are strongly encouraged to have a process in place for responding to member grievances and appeals and must treat each seriously, since practice patterns and trends are tracked as part of the recredentialing process.

According to state law, Health Net Access must respond to member appeals within certain time limits depending upon the urgency of the appeal. The appeal process often requires Health Net Access to review member records that must be obtained from providers. It is important that participating providers promptly submit records requested by Health Net Access.

Appeal Process

Found in: Operations Manuals > Dispute Resolution and Appeals > Member Grievances and Appeals
Effective 06/08/2016

Expedited Appeals

Members can request expedited resolution to an appeal. The expedited resolution to an appeal is requested when a standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The timeframe for an expedited appeal is no longer than three business days after Health Net Access receives the appeal.

A member or provider can initiate the expedited medical review by mailing, faxing or telephoning the request to the Health Net Access Member Appeals and Grievances Department. Once Health Net Access receives the necessary information, Health Net Access provides an acknowledgement within one business day.

Standard Appeals

A standard appeal may be requested if Health Net Access has denied a request for prior authorization or a claim for payment for services already received. A request for an appeal can be submitted by calling the Health Net Access Member Services Center or by mailing or faxing the request to the Health Net Access Member Grievances and Appeals Department. Health Net Access sends the member an acknowledgement within five business days of receiving the appeal. Health Net Access responds with a decision within 30 days of receipt, and may uphold the original decision or overturn it and approve the requested medical services or pay the claim.

If an expedited or standard appeal is denied or the resolution is not completed when the timeframe expires, the member may file a request for a state fair hearing.

Extensions

Health Net Access' time frame for appeal resolution is three business days for an expedited appeal and 30 calendar days for a standard appeal. Expedited and standard appeals may have a 14 calendar day extension beyond the usual resolution timeframe. The member may request the extension, or Health Net Access can request the extension if there is a need for additional information and the delay is in the member's interest. If Health Net Access requests the extension, Health Net Access sends the member a written notice of the reason for the extension.

Continuation of Services

Members may request continued services when they file appeals. Members must make this request within 10 business days from the date of the Notice of Action or the intended date of the action, whichever is later. Services are continued if they were previously authorized and the original period covered by the authorization has not expired. The benefits must then be continued until one of the following occurs:

- The member withdraws the appeal
- A period of 10 business days passes after the Grievance and Appeal Case Coordinator mails the notice of resolution (unless within that 10 business day time-frame the member requested continuation of the benefit pending the hearing process)
- The member receives an adverse hearing decision

If the appeal decision is unfavorable to the member, he or she may be responsible for paying for these services provided during the appeal.

State Fair Hearing

If a member disagrees with the resolution of an expedited or standard appeal, he or she may file a request for a state fair hearing in writing within 30 days of receipt of the Health Net Access denial. The process for requesting a hearing is provided in the

decision letter. The hearing is conducted by an administrative law judge at the Office of Administrative Hearings.

Grievance Process

Found in: Operations Manuals > Dispute Resolution and Appeals > Member Grievances and Appeals
Effective 07/01/2013

A member may file a grievance at any time by telephone, mail or in person when he or she has a concern about the quality of care or service received. Health Net Access provides reasonable assistance in completing forms and taking other procedural steps.This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability in the filing process of a grievance. Grievances may be resolved within 10 business days of receipt, barring extraordinary circumstances, and will not exceed 90 calendar days for resolution.

Grievances must be filed with Health Net Access. Members are not permitted to file a grievance directly with the state. The findings and decisions made by Health Net Access regarding a grievance are final; there is no state fair hearing process available to members for grievances.

Provider Appeals

Found in: Operations Manuals > Dispute Resolution and Appeals Effective 01/01/2003

Provider Dispute Resolutions Process

Found in: Operations Manuals > Dispute Resolution and Appeals > Provider Appeals
Effective 05/12/2016

General Information

Providers should exhaust all authorized processing or resubmisson procedures before filing a claim dispute with Health Net Access.

It is recommended that providers follow the guidelines below before filing a claim dispute:

- If the provider has not received a Health Net Access remittance advice (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 for Health Net Access 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 the Arizona Health Care Cost Containment System (AHCCCS).

Definition of a Provider Dispute

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 or adjusted.
- Challenges a request for reimbursement for an overpayment of a claim.
- Seeks resolution of a billing determination.

Provider Dispute Time Frame

Health Net Access accepts disputes 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.

Submission of Provider Disputes

Providers should submit provider disputes on a Provider Dispute Resolution Request form and send to Health Net Access Provider Disputes. If the dispute is for multiple and

substantially similar claims, a Provider Dispute Resolution Request spreadsheet should be submitted along with the form.

The provider's dispute must include the provider's name, identification (ID) number, contact information with telephone number, and the number assigned to the original claim. 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.

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 will be processed through the member appeals process, granted the member has authorized the provider to appeal on the member's behalf. When a provider submits a dispute on behalf of a member, the provider is assisting the member with his or her member appeal and it should be submitted through the member appeals and grievances process.

If the provider dispute involves a member, the dispute must include the member's name, ID number, a clear explanation of the disputed item, the date of service, billed and paid amounts, and the provider's position. 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 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.

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 when 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 appeal process, Health Net Access reprocesses and pays the claim in a manner consistent with the decision along with any applicable interest within 15 business days of the date of the decision.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Found in: Operations Manuals Effective 07/01/2013

Program Description

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
Effective 05/23/2016

The Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under age 21. EPSDT services include screening services, vision services, dental services,

hearing services, and all other medically necessary, mandatory and optional services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost-effectiveness, do not apply to EPSDT services. All primary care providers (PCPs) who provide services to members under age 21 are required to provide comprehensive health care, screening and preventive services, including, but not limited to:

- primary prevention
- early intervention
- diagnosis
- medically necessary treatment
- follow-up care of physical and behavioral health conditions
- all services required to treat or improve a defect, problem or condition identified in an EPSDT screening

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services listed in the AHCCCS EPSDT Periodicity Schedule and AHCCCS Dental Periodicity Schedule.

EPSDT includes, but is not limited to, coverage of inpatient and outpatient hospital services, laboratory and X-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services.

EPSDT services do not include services that are experimental, solely for cosmetic purposes or not cost-effective when compared to other interventions or treatments.

Arizona Early Intervention Program Procedures

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 02/23/2015

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 primary care physician (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 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 provide 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 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 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, conduct 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.

Care Coordination

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 07/01/2013

Primary care physicians (PCPs) in their care coordination roles serve as referral agents for specialty and referral treatments and services provided to Health Net Access members assigned to them, and attempt to 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
- Verify 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
- Refer potentially eligible children to Children's Rehabilitative Services (CRS)
- Provide the appropriate authorization to have the services provided by a nonparticipating provider when the member requires services that are unavailable in Health Net's provider network
- Request care coordination from Health Net's Health Care Services Department if indicated for the member's condition
- Process for coordination of care and services by appropriate state agencies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible members (such as Children's Rehabilitative Services (CRS), Arizona Early Intervention Program (AzEIP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC),

Vaccines for Children (VFC), Arizona State Immunization Information System (ASIIS), Head Start)

Documentation Requirements

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 07/01/2013

All Early and Periodic Screening, Diagnosis, and Treatment (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. Electronic medical records must include all the elements of 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 an electronic signature must be used).

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 Encounter Department.

EPSDT Screening Schedule

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 07/01/2013

Participating providers are required to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings to Medicaid members under age 21. EPSDT screening services should reflect the age of the child and should be provided periodically according to the following schedule:

- Neonatal exam (2-4 days)
- Under 6 weeks (1 month)
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 3 years
- 4 years
- 5 years
- 6 years
- 7-8 years
- 9-12 years
- 13-17 years
- 18-21 years

Reminders are mailed to Health Net Access members who have not received EPSDT screening, advising them to contact their primary care physician (PCP) to schedule an appointment for the screening.

Follow-Up for Missed Appointments

No-show appointments must be followed up with a telephone call or a letter from the provider's office to the member's parent or guardian to schedule another appointment (this includes the member's failure to follow-up on a referral to a specialist). Place a copy of the letter and documentation of any follow-up attempts in the member's medical record. After two no-shows, PCPs should contact Health Net's maternal child health (MCH)/EPSDT manager. The MCH/EPSDT manager:

- Coordinates with members and providers to reduce no-show appointment rates for EPSDT services
- Provides targeted outreach to those members who do not show for appointments
- Encourages providers to schedule the next periodic screen at the current office visit, especially for children ages 24 months and younger

Other Covered EPSDT Services

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 05/23/2016

Eye Examinations and Prescriptive Lenses

EPSDT includes eye exams and prescriptive lenses to correct or ameliorate defects, physical illness and conditions. PCPs are required to perform basic eye exams and refer members to

the contracting vision provider for further assessment.

Tuberculin Skin Testing

Providers should perform tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with individuals:

- Confined due to TB or suspected of TB.
- In jail during the last five years.
- Living in a household with an HIV-infected individual or the child is infected with HIV traveling/emigrating from, or having significant contact with individuals indigenous to, endemic countries.

Conscious Sedation

AHCCCS covers conscious sedation for members receiving EPSDT services. Coverage is limited to the following procedures except as specified below:

- bone marrow biopsy with needle or trocar
- bone marrow aspiration
- intravenous chemotherapy administration - push technique
- chemotherapy administration into central nervous system by spinal puncture
- diagnostic lumbar spinal puncture
- therapeutic spinal puncture for drainage of cerebrospinal fluid

Additional applications of conscious sedation for members receiving EPSDT services are considered on a case-by-case basis and require medical review and prior authorization by Health Net Access for enrolled members.

Religious Non-Medical Health Care Institution Services

Services received in religious non-medical health care institutions are covered for members eligible for EPSDT.

Chiropractic Services

Chiropractic services are covered when ordered by a member's PCP and approved by Health Net Access.

Personal Care Services

Personal care services are covered, as appropriate, for EPSDT members.

Incontinence Briefs

Health Net Access covers incontinence briefs, including pull-ups and incontinence pads, for EPSDT members to prevent skin breakdown and to enable participation in social, community, therapeutic, and educational activities when the following conditions are met:

- Member is over age 3 and under age 21.
- Member is incontinent due to a documented disability that causes incontinence of bowel or bladder.
- PCP or attending physician has issued a prescription ordering the incontinence briefs.

Prior authorization is required for incontinence products and must be renewed every 12 months. Supplies must be obtained from Health Net Access's DME preferred provider. Up to 240 briefs per month are covered unless the member's PCP or attending physician provides documentation to support medical necessity for a larger supply.

Medically Necessary Therapies

Physical therapy, occupational therapy and speech therapy necessary to correct or ameliorate defects and physical and mental illnesses discovered by screening services are covered under both inpatient and outpatient bases as medically necessary.

Organ and Tissue Transplantation Services

Organ and tissue transplantation services are covered, as appropriate, for EPSDT members (see Transplant Services for additional information).

Parent's Evaluation of Developmental Screening Tool

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 07/01/2013

Primary care physicians (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 can be obtained by contacting the maternal child health MCH/EPSDT manager.

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. Providers must be trained prior to using the tool. All PCPs must complete PEDS tool training in order to bill Health Net Access. PEDS tool trained providers are reimbursed for using the tool on members who are graduates from the NICU.

The Health Net maternal child health MCH/EPSDT manager:

- Works with providers to ensure utilization of the Arizona Health Care Cost Containment System (AHCCCS)-approved standard developmental screening tools and complete training in the use of the tools
- Assist families with NICU-discharged children in the selection of PEDS-trained providers
- Notify PCPs when a NICU-discharged member is assigned to their panel
- Monitor providers for compliance with training and use of the PEDS tool
- Implement 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

Problem Resolution

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 07/01/2013

Health Net's maternal child health (MCH)/EPSDT manager resolve disputes that arise regarding responsibility for necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Health Net Health Services staff continues to coordinate and authorize all immediate health care needs in collaboration with the primary care physician (PCP) until the matter is resolved.

Procedural Requirement for EPSDT Providers

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 05/23/2016

PCPs are required to comply with EPSDT regulatory requirements, including the following:

- Document immunizations within 30 days of immunization to the Arizona State Immunization Information System (ASIIS).
    - Enroll every year in the Vaccines for Children (VFC) program.
- Provide all screening services according to the AHCCCS Periodicity Schedule and community standards of practice.
- Ensure all infants receive both the first and second newborn screening tests.
    - Specimens for the second test may be drawn at the PCP's office and mailed directly to the Arizona State Laboratory, or the member may be referred to the contracting laboratory for the draw.
- Providers must use the standardized EPSDT Tracking Forms provided by AHCCCS (or an electronic equivalent that includes all components from the hard-copy form) at every EPSDT visit. EPSDT Tracking Forms are available on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf.
- Send copies of EPSDT tracking forms to Health Net Access on a monthly basis, at a minimum. Fax forms to the EPSDT fax line.
- Use all clinical encounters to assess the need for EPSDT screening and services.
- Document in the medical record the member's decision not to participate in the EPSDT program, if appropriate.
- Make referrals for diagnosis and treatment when necessary and initiate follow-up services within 60 days.
- Schedule the next appointment at the time of the current office visit for children ages 24 months and younger.
- Report all EPSDT encounters on required claim forms, using the Preventive Medicine Codes.
- Refer members to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program.
- Referring members to 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.

An EPSDT well-child visit must include the following basic elements:

- Comprehensive health and developmental history, including growth and development screening (includes physical, nutritional and behavioral health assessments).
- Developmental screening (using an AHCCCS-approved developmental screening tool) for members ages 9, 18 and 24 months.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history.
- Laboratory tests appropriate to age and risk for blood lead, tuberculosis skin testing, anemia testing and sickle cell trait.

- Health education, counseling, chronic disease self-management, counseling about child development, healthy lifestyles and accident and disease prevention.
- Appropriate dental screening and referral.
- Fluoride varnish application every six months (by providers who have completed training) for members' age 6-24 months with at least one tooth eruption.
- Appropriate vision and hearing/speech testing.
- Nutritional assessment.
- Obesity screening using the body mass index (BMI) percentile for children.
- Behavioral health screening and services.
- Tuberculin skin testing.
- Preventive guidance.

Health Education

PCPs are responsible for ensuring health counseling and education are provided at each EPSDT visit. PCPs should discuss preventive guidance, so parents or guardians know what to expect with respect to the child's development. PCPs should also cover accident and disease prevention, and the benefits of a healthy lifestyle.

Screenings

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
Effective 05/23/2016

Periodic Screenings

The AHCCCS EPSDT Periodicity Schedule specifies the screening services to be provided at each stage of a child's development. The schedule follows American Academy of Pediatrics recommendations.

Children may receive additional interperiodic screening at the discretion of the provider. Health Net Access does not limit the number of well-child visits that members under age 21 receive.

Annual well-child visits are comprehensive and should include all of the services required for sports or other activities. Physicals completed solely for the purpose of sports activities are not covered by AHCCCS; therefore, no additional payment would be made.

Developmental Screening Tools

Primary care providers (PCPs) must be trained in the use and scoring of developmental screening tools. Training resources may be found at Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php.

The following developmental screening tools are available for members at their 9-, 18- and 24-month EPSDT visit:

- Ages and Stages Questionnaires™ Third Edition (ASQ) is a tool used to identify developmental delays in the first five years of a child's life. The sooner a delay or disability is identified, the sooner a child can be connected with services and support that make a real difference. The tool is available online at www.agesandstages.com.
- Ages and Stages Questionnaires®: Social-Emotional (ASQ: SE) is a tool used to identify developmental delays for social-emotional screening. The tool is available at www.agesandstages.com.
- The Modified Checklist for Autism in Toddlers (M-CHAT) used only as a screening tool by a PCP, for members ages16 to 30 months, to screen for autism when medically indicated. The tool is available online at www.m-chat.org.
- The Parents' Evaluation of Developmental Status (PEDS) used for developmental screening of EPSDT-aged members. The tool is available online at www.pedstest.com or www.forepath.org.

Payment for use of screening tools is covered when the following criteria are met:

- The member's EPSDT visit is at 9, 18, or 24 months.
- Prior to providing the service, the provider must complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to the Council for Affordable Quality Healthcare (CAQH).
- The code is appropriately billed (96110-EP).

Providers must retain copies of the completed tools in the member's medical record and submit it to Health Net Access with the completed EPSDT Tracking Form.

EPSDT Oral Health Care Screening and Referrals

The PCP must screen children younger than age three at each EPSDT visit to identify those who require a dental referral for evaluation and treatment.

PCPs and attending physicians must refer EPSDT recipients to dentists for appropriate services based on the needs identified through the screening process and for routine dental care at

least annually based on the AHCCCS EPSDT Periodicity Schedule. The American Association of Pediatric Dentistry recommends that dental visits begin by age one, but the referral isn't mandatory until age three. Evidence of the referral must be documented on the ESPDT Tracking Form and in the recipient's medical record. Documented dental findings and treatment must be included in the member's medical record in the PCP's office. Depending on the results of the oral health screening, referral to a dentist should be made according to the following time frames:

- Urgent (within 24 hours) - pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer.
- Early (within three weeks) - decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas.
- Routine (next regular checkup) - none of the above problems identified.

The member's parent or guardian may also self-refer and schedule dental appointments for the member with any contracting general dentist. Members may go directly to the dentist without seeing the PCP first and no authorization is required.

Health Net Access assigns members under age 21 to a dental home and encourages referrals to the dentist begin at age one for routine preventive care and according to the AHCCCS EPSDT Periodicity Schedule. The physician may refer EPSDT recipients for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least age six months, with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until the recipient's second birthday, are also reimbursed.

AHCCCS recommended training for fluoride varnish application is located at the Smiles for Life website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should upload a copy of their certificate to the Council for Affordable Quality Healthcare (CAQH) site. This certificate is used in the credentialing process to verify completion of training necessary for reimbursement. An oral health screening must be part of an EPSDT screening conducted by a PCP; however, it does not substitute for examination through direct referral to a dentist. PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member's medical record.

Blood Lead Screening

All children are considered at risk of and must be screened for lead poisoning. Children at ages 12 and 24 months must receive a blood lead test. Children between ages 36 and 72 months must receive a blood lead test if they have not been previously screened.

A verbal risk assessment must be completed at each EPSDT visit for children 6 through 72 months to determine risk category and the need for any follow-up services.

Providers must report blood lead levels equal to or greater than 10 micrograms of lead per deciliter of whole blood to the ADHS.

Hearing and Speech Screening

Hearing evaluation consists of appropriate hearing screens given according to the EPSDT schedule. Evaluation consists of history, risk factors, parental questions, and impedance testing. Pure-tone testing should be performed when medically necessary.

Speech screening must be performed to assess the member's language development at each EPSDT visit.

Cochlear and Osseointegrated Implantation

When determined medically necessary, Health Net Access covers cochlear implantation and osseointegrated implants for EPSDT members. Cochlear implantation is limited to one functioning implant per member. Cochlear and osseointegrated implantation require prior authorization.

Behavioral Health Screening

Screenings for mental health and substance abuse problems must be conducted at each EPSDT visit. Treatment services are a covered benefit for members under age 21.

PCPs are expected to:

- Initiate and coordinate necessary referrals with the Regional Behavioral Health Authority (RBHA) for behavioral health services.
- Monitor whether a member has received services.
- Keep any information received from a behavioral health provider regarding the member in the member's medical record.

- Initial and date copies of referrals or information sent to a behavioral health provider before placing in the member's medical record.
    - If the member has not yet been seen by the PCP, this information may be kept in an appropriately labeled file in lieu of actually establishing a medical record, but must be associated with the member's medical record as soon as one is established.

PCPs may treat attention deficit hyperactivity disorder (ADHD), depression and anxiety. All other behavioral health conditions must be referred to the RBHA. PCPs that elect to prescribe medications to treat ADHD, depression or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan.

Health Net Access requests PCPs to implement postpartum depression screenings to identify and refer mothers who would benefit from additional treatment due to concerns related to postpartum depression during EPSDT visits for infants up to age one.

Nutritional Assessment & Nutritional Therapy

Nutritional therapy for EPSDT members on an enteral, parenteral or oral basis is covered when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

The following requirements apply:

- Medical foods must be essential to sustain the member's growth within nationally recognized height/weight or body mass index (BMI) levels, maintain health and support metabolic balance.
- PCPs must complete the Certificate of Medical Necessity for EPSDT members form and fax to Health Net Access Prior Authorization Department.
- PCPs must reassess needs at each visit.
- PCPs must refer members in need of nutritional therapy for consult with both a metabolic nutritionist and genetic specialist.
    - Health Net Access utilizes the metabolic nutritionist at Phoenix Children's Hospital.
    - The metabolic nutritionist works with the member and guardian to develop a treatment plan to meet the member's needs and requests prior authorization from Health Net Access, as applicable.

- The diagnosis must be documented in the medical record and should include the test results used in establishing the diagnosis.
- Nutritional therapy requires prior authorization and approval by the Health Net Access medical director or other qualified health professional designee.
- After prior authorization has been issued, the Health Net Access Prior Authorization Department sends the request to the medical foods vendor.

Body Mass Index

Primary care providers (PCPs) should calculate each child's body mass index (BMI) starting at age three until the member is age 21. BMI is used to assess underweight, overweight and those at risk for overweight. BMI for children is gender and age specific. PCPs are required to calculate the child's BMI and percentile. Additional information is available at the Centers for Disease Control and Prevention (CDC) website regarding BMI.

The following established percentile cutoff points are used to identify underweight and overweight in children:

BMI Table

BMI (kg/m^2)	**Classification**
>= 95^{th} percentile	Obese
85^{th} to < 95^{th} percentile	Overweight
5^{th} to < 85^{th} percentile	Healthy Weight
< 5^{th} percentile	Underweight

State Programs

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
Effective 05/23/2016

Arizona Early Intervention Program

The Arizona Early Intervention Program (AzEIP) is an early intervention program that offers a statewide system of support and services for children who have disabilities or developmental delays, from birth through age three and their families. This program was jointly developed and implemented by AHCCCS and AzEIP to ensure the coordination and provision of EPSDT and

early intervention services, such as physical therapy, occupational therapy, speech/language therapy, and care coordination under Section 1905 [42 U.S.C 1396d]. Concerns about a child's development may be initially identified by the child's primary care provider (PCP) or by AzEIP.

Health Net Access coordinates with AzEIP to ensure that members receive medically necessary EPSDT services in a timely manner to promote optimum child health and development. For additional information, contact the Health Net Access EPSDT coordinator.

Head Start Program

Head Start and Early Head Start programs are federal programs provided at no cost to families.

Head Start promotes school readiness of children from birth to age five from low-income families by enhancing their cognitive, social and emotional development. Head Start programs provide a learning environment that supports children's growth in many areas, such as language, literacy, and social and emotional development. Head Start emphasizes the role of parents as their child's first and most important teacher. These programs help build relationships with families that support family well-being and many other important areas.

Early Head Start Programs serve infants, toddlers and pregnant women and their families who have incomes below the federal poverty level.

PCPs and other community advocates may directly refer members to the Head Start program. Parents and guardians may self-refer.

Visit the Head Start website for additional information ateclkc.ohs.acf.hhs.gov/hslc. Providers may also contact Maternal Child Health Case Management for referral assistance.

Women Infant and Children

The Arizona Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition education and breastfeeding support services, supplemental nutritious foods and referrals to health and social services. WIC serves pregnant, breastfeeding and postpartum women; infants; and children under age five who are determined to be at nutritional risk. The WIC program is funded by the United States Department of Agriculture.

For more information about WIC, visit the ADHS website at azdhs.gov/prevention/azwic/index.php.

Children's Rehabilitative Services

The Arizona Children's Rehabilitative Services (CRS) program provides medical treatment, rehabilitation and related support services to AHCCCS members who meet the eligibility criteria to be enrolled in CRS.

Providers may fax CRS referrals for eligible Health Net Access members and supporting medical records to the Health Net Access CRS coordinator . For more information and assistance with referrals, contact Health Net Access Behavioral Health Case Management.

Providers may access the CRS Application forms and instructions at AHCCCS website at: azahcccs.gov/PlansProviders/CurrentProviders/CRSreferrals.html.

For general questions regarding the CRS Program contact the AHCCCS CRS Enrollment Unit or contact the United Healthcare Community Plan CRS Provider Ombudsman.

Vaccine for Children Program

Found in: Operations Manuals > Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Effective 05/23/2016

EPSDT covers all child and adolescent immunizations. Immunizations must be provided according to the Arizona Health Care Cost Containment System (AHCCCS) Recommended Childhood Immunization Schedules, which follow the CDC guidelines and must be up-to-date. Providers are required to coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program to obtain vaccines for Health Net Access members who are ages 18 and under.

Current immunization schedules are available on the CDC website at www.cdc.gov/vaccines/schedules/index.html. Additional information can be attained by calling VFC or by accessing the ADHS website at www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#vaccines-children-home.

Arizona law requires the reporting of all immunizations administered to children under age 19. Immunizations must be reported at least monthly to ADHS. Reported immunizations are held in a central database, the Arizona State Immunization Information System (ASIIS), and can be accessed online to obtain complete, accurate records.

Health Net Access requests that all primary care providers (PCPs) and pediatricians caring for newborns review each member's immunization records fully upon the initial visit, and subsequent follow-up visits, regardless of where the child was delivered. Newborns must receive all required vaccines and those who have not received the birth dose of the hepatitis B vaccine in the hospital must be caught up by their PCP.

EPSDT Program - AHCCCS EPSDT Periodicity Schedule

EXHIBIT 430-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

PROCEDURE/AGE	Newborn	3-5 days	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Length/Height & Weight	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Weight for Length	x	x	x	x	x	x	x	x	x	x																			
Head Circumference	x	x	x	x	x	x	x	x	x	x	x																		
Body Mass Index (BMI)											x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Blood Pressure – PCP should assess the need for B/P measurement for children birth to 24 months	+	+	+	+	+	+	+	+	+	+	+	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision/Hearing/Speech	SEE SEPARATE SCHEDULE																												
Developmental Surveillance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Developmental Screening [1]							x			x	x																		
Psychosocial/Behavioral Assessment (Social-Emotional Health)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Alcohol and Drug Use Assessment																				+	+	+	+	+	+	+	+	+	+
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Newborn Metabolic Screening [2]	←	x	→																										
Immunizations	SEE CENTERS FOR DISEASE CONTROL AND PREVENTION WEBSITE																												
Tuberculin Test								+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin							+	x	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Lead Screening/Testing	OUTSIDE HIGH RISK ZIP CODE																												
Verbal Lead Screen						x	x	x		x	x	x	x	x	x														
Blood Lead Testing						+	+	+		+	+	+	+	+	+														
Lead Screening/Testing	WITHIN HIGH RISK ZIP CODE																												
Verbal Lead Screen						x	x		x	x		x	x	x	x														
Blood Lead Testing								x			x	x*	x*	x*	x*														
Dyslipidemia Screening											x		x		x		x		x	x	x	x	x	x	x	x	x	x	x
Dyslipidemia Testing	ONE TIME TESTING BETWEEN 18 AND 20 YEARS OF AGE																												
STI Screening																			+	+	+	+	+	+	+	+	+	+	+
Cervical Dysplasia Screening																			+	+	+	+	+	+	+	+	+	+	+
Oral Health Screening by PCP [3]						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Topical Fluoride Varnish [4]						x	→	x	→	x																			
Dental Referral [5]						+	+	x	+	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

EXHIBIT 430-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

*** See Separate Schedules within AMPM Chapter 400 for Vision, Hearing/Speech, and Immunizations

[1] Utilization of one AHCCCS approved developmental screening tools (ASQ and PEDS Tool) for members at 9, 18, and 24 months of age. The MCHAT may be used for members 16-30 months of age to assess the risk of autism spectrum disorders in place of the ASQ or PEDS Tool when medically indicated.

[2] Newborn metabolic screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.

[3] Oral health screenings to be conducted by the PCP at each visit starting at 6 months of age.

[4] Fluoride varnish is limited in a primary care provider's office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

[5] First dental examination is encouraged to occur by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key: x = to be completed
\+ = to be performed for members at risk when indicated
←— x —→ = the range during which a service may be provided, with the x indicating the preferred age
* = Members not previously screened who fall within this range (36 to 72 months of age) must have a blood lead test performed

NOTE: If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered.

NOTE: The American Association of Pediatric Dentistry recommends that dental visits begin by age one (1). Referrals should be encouraged by one (1) year of age. Parents of young children may self-refer to a dentist within the Contractor's network at any time.

Revised: 04/01/15, 04/01/2014, 02/01/2011, 10/1/2008, 4/1/2007, 10/23/2006

EXHIBIT 430-1 (continued)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE

PROCEDURE/AGE	New born	3-5 days	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr
Vision +	S	S	S	S	S	S	S	S	S	S	S	O*	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key:
S = Subjective, by history
O = Objective, by a standard testing method
*** = If the member is uncooperative, rescreen in 6 months.**
+ = May be done more frequently if indicated or at increased risk.

Ocular photoscreening with interpretation and report, bilateral is covered for children ages three to five as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one.

Revised: 04/01/15, 04/01/2014, 4/1/2007, 8/1/2005

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING/SPEECH SCHEDULE

PROCEDURE/AGE	New born	3-5 days	2 Wks	By 1mo	6 Wks	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr
Hearing/Speech +	O**	S	O**	←—	—→	S	S	S	S	S	S	S	S	S	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key:
S = Subjective, by history
O = Objective, by a standard testing method
*** = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.**
+ = May be done more frequently if indicated or at increased risk
**** = All newborns should be screened for hearing loss at birth and again 2 to 6 weeks afterward if indicated by the first screening or if a screening was not completed at birth.**

Revised: 04/01/15, 04/01/2014, 4/1/2007, 8/1/2005

Eligibility

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Eligibility Effective 07/01/2013

Eligibility for Arizona Health Care Cost Containment System (AHCCCS) is determined by different agencies depending on the program to which the member is applying. These agencies/entities include AHCCCS, Department of Economic Security (DES) and the Social Security Administration (SSA).

For most members, eligibility is effective from the first day of the month of application or the first day of the month in which the member meets the qualification for AHCCCS coverage or the date of birth, whichever is later.

Eligibility Verification

Found in: Operations Manuals > Eligibility Effective 06/08/2016

Providers are responsible for verifying eligibility each time a member schedules an appointment and when all medical services are provided. The member's assigned primary care provider (PCP) must also be verified prior to rendering primary care services. Health Net Access does not reimburse providers for services rendered to members who lost eligibility or were not assigned to the PCP's panel unless the provider is a physician covering for a PCP.

Providers may verify member eligibility with one of the following:

- Health Net Access provider website at www.healthnetaccess.com. Providers must be registered and have a password.
- MediFax: An electronic system available through AHCCCS that stores key member information. Use to verify member eligibility for pharmacy, dental, transportation and specialty care.
- AHCCCS interactive voice response (IVR). There are two contacts, one for providers within Maricopa County and another for providers outside of Maricopa County.
- Health Net Access telephone verification through the Provider Services Center (to be use as the last resort). To protect member confidentiality, providers are asked for at least three pieces of identifying information, such as member identification number, date of birth and address, before any eligibility information can be released. When calling, use the prompt for the providers.

Newborn Eligibility

Found in: Operations Manuals > Eligibility Effective 07/01/2013

All babies born to Arizona Health Care Cost Containment System (AHCCCS)-eligible mothers are also AHCCCS-eligible and may remain eligible for up to one year if the newborn continues to reside in Arizona.

Newborns born to mothers receiving Federal Emergency Services (FES) are also eligible for up to age one. The mother is covered under FESP; the newborn is enrolled in an AHCCCS health plan.

Newborns born to mothers enrolled in KidsCare are approved for KidsCare beginning with the newborn's date of birth unless the child is eligible for Medicaid.

Newborns receive separate AHCCCS identification (ID) numbers and services for them must be billed separately using the newborn's ID. Services for a newborn that are included on the mother's claim are denied.

Encounters

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Encounters Effective 05/23/2016

An encounter is a claims record of medical services provided to a member enrolled in the Health Net Access plan. Providers are required to submit claims to Health Net for all services rendered to Access members on the most current CMS-1500, UB-04 or other appropriate claim form. Providers may access Claims Submission Requirements in the Claims and Provider Reimbursement section of the provider operations manual for claims submission details.

Health Net is required to send encounter data electronically to AHCCCS. Accordingly, providers' reporting of complete and accurate claims data to Health Net is critical.

Enrollment

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Enrollment Effective 07/01/2013

Arizona Health Care Cost Containment System (AHCCCS) pre-enrolls most acute care members in the health plan of their choice when they apply for eligibility through the Arizona Department of Economic Security (DES) and the Social Security Administration (SSA).

Members who select a health plan while waiting for eligibility determination are enrolled on the same day as the eligibility determination date. Members who do not select a health plan are auto-assigned a health plan and have 30 days to enroll in a different health plan if desired.

Providers are reimbursed for covered services during the prior period coverage (PPC) time frame. The PPC is the period between the member's starting date of AHCCCS eligibility and the date of enrollment with Health Net.

Health Net Access members who maintain eligibility may change plans once a year during their enrollment anniversary month. The enrollment anniversary month is the month in which a member was first enrolled in one of the state health program plans.

Coverage Out of State

Found in: Operations Manuals > Enrollment Effective 07/01/2013

A member who is temporarily out of state, but still an Arizona resident, is entitled to receive Arizona Health Care Cost Containment System (AHCCCS) benefits under any of the following conditions:

- Medical services are required due to a medical emergency
- Documentation of the emergency must be submitted with the claim
- The member requires a particular treatment that can only be obtained in another state
- The member has a chronic illness necessitating treatment during a temporary absence from the state, or the member's condition must be stabilized before returning to the state

Services furnished to AHCCCS members outside the United States are not covered.

Glossary of Terms

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Glossary of Terms Effective 10/01/2015

This glossary is provided for reference purposes and is not intended to supersede definitions or explanations contained in controlling or governing documents, such as the *Provider Participation Agreement* (*PPA*) or the member's *Evidence of Coverage* (*EOC*).

ARIZONA DEPARTMENT OF INSURANCE (ADOI) - State of Arizona regulatory body responsible for oversight of insurance companies, including HMOs and PPOs.

ARIZONA EARLY INTERVENTION PROGRAM (AzEIP) - Provides services to children from birth through age three, who are at risk of or have a developmental delay, and their families.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - State of Arizona regulatory body responsible for Medicaid.

ARIZONA STATE IMMUNIZATION INFORMATION SYSTEM (ASIIS) - The central database maintained by the Arizona Department of Health Services to record all immunizations administered to children under age 19.

APPEAL - A means to provide physicians, practitioners, facilities, and members with an avenue for reconsideration of Health Net's action, including, but not limited to, non-payment of services or authorization denial.

APPEALS AND GRIEVANCES DEPARTMENT - Health Net department designated to resolve member appeals and complaints.

CAPITATION PAYMENT - Predetermined periodic payment, which can be based upon the rate code, age and gender of assigned members that is made to a participating physician or other provider by Health Net for providing covered services.

CARVE-OUT - Any service identified by an ICD-10-CM diagnosis code, CPT procedure code, patient age, or CPT modifier that is eligible for fee schedule reimbursement.

CLAIMS FILING DEADLINE - All claims where Health Net is the primary payer must be submitted within 120 calendar days of the service date. Claims submitted more than 120 days

after the date of service are denied. In no event does Health Net consider the filing of a claim or appeal of a denial of a claim more than one year from the date of service.

CLAIMS RECOVERY UNIT - A multiunit recovery area for Health Net that encompasses coordination of benefits (COB), medical-pay benefits, subrogation, refunds, and cash-receipt tracking.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) - A federal agency within the Department of Health and Human Services, responsible for oversight of the federal requirements of the health care industry for Medicare recipients and Medicare benefits. It is the governing body over Medicare Advantage (MA) plans.

COINSURANCE - Portion of a covered charge that the member must pay for covered services and supplies. Coinsurance amounts are shown in the *Schedule of Benefits*. For example, coinsurance may be shown as 20 percent. This means the member pays 20 percent of covered charges and Health Net pays 80 percent of covered charges.

COMPLAINT - Any verbal or written expression of dissatisfaction by a physician or member.

CONCURRENT REVIEW NURSE - Nurse assigned to coordinate inpatient discharge needs or services.

COPAYMENT - Fixed amount of out-of-pocket expenses that a member is required to pay a participating provider when receiving covered services. Copayments are due to the provider at the time covered services are received. Copayments may be in addition to coinsurance or deductible amounts the member must pay under his or her plan, dependent upon the plan selected by the member's employer.

COVERED SERVICES - Medically necessary health and medical services, as defined in the member's plan document. Some services may be noted as covered only with prior authorization.

CUSTOMER SERVICE - Health Net staff designated to coordinate communication with members and act as member advocates. Customer service representatives also assist physicians, clinicians and other providers with claims and eligibility questions.

DEDUCTIBLE - Amount of money that must be paid each year by the member before Health Net's obligation to provide covered benefits arises.

DENIAL - An unfavorable determination made regarding any claim, service or appeal.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM - A comprehensive child health program to prevent, treat, correct, and improve physical and mental health problems for Medicaid members under age 21.

EMERGENCY MEDICAL CONDITION - Health care services provided to a member for a medical condition that manifests itself by symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the patient's health, or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

EMERGENCY SERVICES - Covered inpatient and outpatient services:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition

ENCOUNTER - Record of medical services provided to a member where services were prepaid.

ENROLLMENT - Process by which a person who has been determined eligible becomes a member of Health Net.

GRIEVANCE - Any member's complaint or dispute other than one involving an organization determination. Examples include office waiting times, and physician and staff demeanor and behavior.

HEALTH MAINTENANCE ORGANIZATION (HMO) - An entity that provides, offers or arranges for coverage of designated health services by plan members, usually for a fixed amount.

INTERNATIONAL CLASSIFICATION OF DISEASES - 9TH REVISION - CLINICAL MODIFICATION (ICD-10-CM) - Coding schemata used by physicians to classify a disease into a code value.

INDEMNITY INSURANCE - "Traditional" insurance that provides insurance for health care costs incurred by the member in exchange for a monthly premium. Insurance coverage is generally based on a percentage of the member's actual medical expenses, subject to maximum allowable amounts as determined by the insurance carrier. The member is financially responsible for charges not covered by the insurance carrier. The member does not have a primary care physician (PCP) and may see any physician.

INITIAL DETERMINATION - Written notice that must be provided to a physician denying a request for payment that advises the physician of his or her right to an appeal.

IN-NETWORK - For PPO and Point of Service (POS) plus plans, it refers to care delivered by participating physicians or preferred providers. Also refer to Out-of-Network.

LENGTH OF STAY - Number of days a patient is an inpatient, per admission, either totally or in a particular unit or level of care.

MEDICAL SERVICES - Covered services pertaining to medical care performed at the direction of a physician on behalf of members or eligible persons by physicians, dentists, nurses, or other health-related professionals and technical personnel. Services determined to be necessary for prevention, diagnoses or treatment of a patient or patient condition.

MEDICALLY NECESSARY - CMS defines medical necessity and medically necessary services as services or supplies that: are proper and needed for the diagnosis and treatment of illness or injury, or to improve functioning of a malformed body member, or for prevention of an illness, or for the palliation and management of terminal illness; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or health care provider.

For HMO and PPO plans, medically necessary services or medical necessity is defined as health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas, and any other relevant factors
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Preventive care may be medically necessary, but coverage for medically necessary preventive care is governed by the terms of the *Provider Participation Agreement (PPA)* and the member's *Evidence of Coverage (EOC)*.

When considering whether a service or treatment is experimental or investigational, if such service or treatment is medically necessary, as defined above, said service or treatment is paid for unless specifically excluded from Health Net coverage. "New technology" is defined as a service, procedure, device, test, or other item that, as of the effective date of this agreement (i) is not performed by provider, or (ii) is not covered by Health Net under a benefit program, or (iii) for which there is no CPT or other relevant code defined.

MEDICAID - A health care coverage program that is jointly financed by the state and the federal government for children, pregnant women, parents, seniors, and individuals with disabilities.

MEDICARE - A federal health insurance program for people age 65 or older, some people under age 65 with certain disabilities and people with end-stage renal disease (ESRD) (generally those with permanent kidney failure who need dialysis or a kidney transplant).

MEDICARE ADVANTAGE ORGANIZATION (MAO) - Public or private entity organized and licensed under state law as a risk-bearing entity that is certified by CMS as meeting MA contract requirements. Health Net of Arizona is an MAO.

MEDICARE ADVANTAGE (MA) PLAN - Health benefits coverage and pricing structure that the MAO offers to beneficiaries. SeniorCare and SeniorCare Gold are MA plans.

MEMBER **-** Individual who has been determined eligible by Health Net and enrolled with Health Net or one of its affiliates to receive services.

NOTICE OF ACTION LETTER - A written denial letter to a member regarding a prior authorization request and action by Health Net Access.

NOTICE OF EXTENSION LETTER - A written notice to a member extending the time frame by up to 14 days for making an urgent/expedited or standard prior authorization decision if criteria for a service authorization extension are met.

OUT-OF-AREA CARE - Care received by a Health Net member when outside of the member's service area.

OUT-OF-NETWORK - For PPO and POS plus plans, it refers to care delivered by non-participating/non-preferred physicians. Also refer to In-Network.

PARTICIPATING PHYSICIAN - Physician who has entered into an agreement, or on whose behalf an agreement has been entered into, with Health Net to provide medical services to enrolled

members.

PARTICIPATING PROVIDER - Any person or entity that has entered into a contract with Health Net to provide covered services to enrolled members. Participating providers include, but are not limited to, hospitals, urgent care facilities, physicians, pharmacies, and other health professionals within the
Health Net service area.

PER MEMBER PER MONTH (PMPM) - Dollar amount used to calculate the capitation budget pools.

PHYSICIAN - A person who:

- Is recognized and licensed under the laws of the state where treatment is received as qualified to treat the type of injury or illness for which a claim is made.
- Is practicing within the scope of his or her license.
- Is a duly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or other health professional for whom reimbursement is mandated under applicable Arizona or federal law, when licensed in the state where services are received.

PHYSICIAN SERVICES - Services provided within the scope of practice of medicine or osteopathy or under the personal supervision of an individual licensed under Arizona law to practice medicine or osteopathy.

POINT OF SERVICE (POS) - Health care system in which the patient may choose varied benefit levels based on the desire to control costs (in-network) or to obtain care not coordinated by the primary care physician (PCP) (out-of-network).

PREFERRED PROVIDER ORGANIZATION (PPO) - Health care system in which the patient may choose varied benefit levels based on the desire to control costs (in-network) or to obtain care outside of the Health Net participating or preferred network (out-of-network).

PRIMARY CARE PHYSICIAN (PCP) - Participating physician who provides, arranges and coordinates a member's health care, usually associated only under an HMO plan. PCPs are physicians in the areas of family practice, general medicine, internal medicine, and pediatrics. Upon enrollment, a member selects a physician from the list of participating physicians. Obstetricians may also act as a member's PCP during pregnancy and postpartum periods. Members do not need to contact Health Net to change their PCP to an obstetrician during pregnancy and postpartum periods.

PRIOR AUTHORIZATION/PRE-CERTIFICATION - Prior assessment that proposed health care services are medically appropriate and a covered benefit for a particular member using standard guidelines**.**

PRIORITY ASSIGNMENT - PCPs who are in good standing with Health Net and have excellent availability are eligible for this program. Priority assignment reflects eligible PCPs as "priority" for membership assignment.

PROVIDER INQUIRY DEPARTMENT - Health Net staff designated to assist physicians with questions regarding complaints, appeals and grievances.

PROVIDER NETWORK MANAGEMENT (PNM) - Health Net staff designated to coordinate communication and education between Health Net and physicians or clinicians, and other health care facility and ancillary providers. PNM representatives also assist physicians with network changes and questions regarding policies and covered services.

QUALITY IMPROVEMENT (QI) STAFF - Provides technical support to the QI committees, and conducts QI studies and activities.

REFERRAL - Request made through the PCP for authorization of specialty services or equipment on behalf of a member.

RETROSPECTIVE REVIEW - Formal process of reviewing Health Net/payer-requested medical documentation or invoices to support medical appropriateness of services, medications, costs, or durable medical equipment (DME) submitted for reimbursement, regardless if such service rendered or any procedure involving a member requires authorization.

SERVICE AREA - Geographic area approved by CMS within which a Medicare Advantage (MA)-eligible individual may enroll in a particular MA plan offered by Health Net. For HMO and PPO plans, it is the geographic area serviced by Health Net, as authorized by the state of Arizona and designated by Health Net for the provision of covered services. These areas may change from time-to-time, as designated by Health Net.

SERVICE DENIALS - Medical service authorization requests that are not approved.

URGENT CARE - CMS defines urgently care services as covered services that:

- Are not emergency services as defined by CMS

- Are provided when an enrollee is temporarily absent from the Medicare Advantage (MA) plan's service (or, if applicable, continuation) area, or the plan network is otherwise not

available, and,

- Are medically necessary and immediately required, meaning that:
    - The urgently needed services are a result of an unforeseen illness, injury or condition, and
    - Given the circumstances, it was not reasonable to obtain the services through the MA plan's participating provider network

For HMO and PPO plans, services provided for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties, other than those of sudden onset and persistent severity.

ID Cards

Found in: Operations Manuals Effective 01/01/2003

Overview

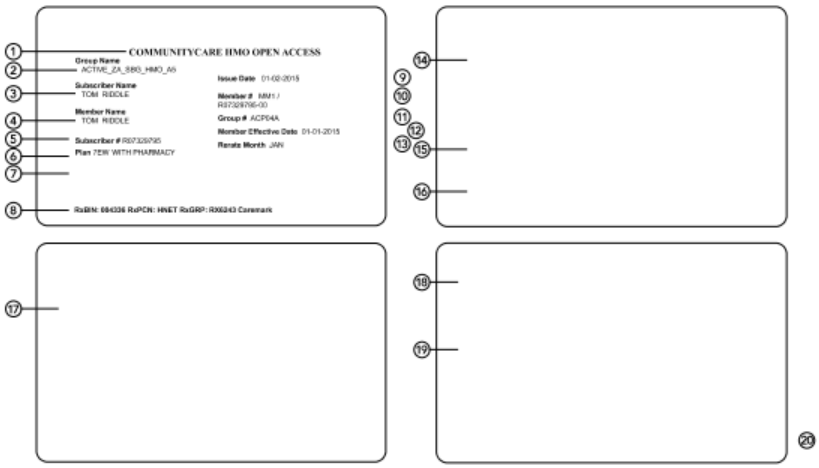
Found in: Operations Manuals > ID Cards Effective 09/13/2016

A new identification (ID) card is automatically sent when:

- A member enrolls
- A member changes his or her name
- A dependent is added or deleted from the policy
- Other changes are made to provider or health plan information

Refer to the sample Health Net Access member ID card to view a picture and general description of a Health Net Access member ID card.

CommunityCare HMO Member ID Card



Identification (ID) Card Components

1 Plan – Name of plan under which the subscriber is enrolled

2 Group name – Employer group name under which the subscriber is enrolled

3 Subscriber name – Name of the policy holder

4 Member name – Name of the member enrolled under the subscriber's plan

5 Subscriber # – Health Net-assigned subscriber ID number

6 Plan – Plan code and additional benefit information

7 Important telephone numbers – Health Net contact telephone numbers

8 Prescription benefit information – Claims information for prescription medication processing vendor

9 Issue date – Date ID card was issued

10 Member # – Health Net-assigned three-character ID number that identifies the member's relationship to the subscriber

11 Group # – Health Net-assigned number that identifies the employer group

12 Member effective date – Date the member was effective with the plan

13 Rerate month – Month in which the member's benefits are renewed each year

14 Plan information – Contact information for plan

15 Copayments – Out-of-pocket expense the member is required to pay for covered services (copayments vary by plan)

16 Pharmacy information – Contact information for Health Net Pharmacy Department and prescription medication processing vendor

17 Claims and correspondence information – Addresses for claims submission and general correspondence, and telephone number for electronic claims submission

18 Emergency information – Instructions to member on what to do for an urgent or emergency health problem

19 Vendor contact – Contact information for participating vendor administering certain plan benefits

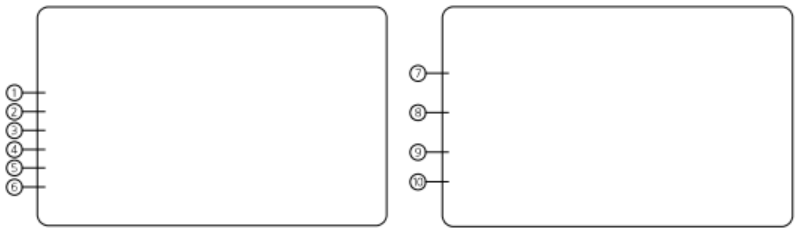
20 MultiPlan logo – Out-of-network claims negotiation vendor

Health Net

Health Net Access Member ID Card Sample

Found in: Operations Manuals > ID Cards Effective 07/01/2013

Sample Health Net Access Member ID Card



Identification (ID) Card Components

1 Member name – Name of the Health Net Access member

2 AHCCCS ID# – Arizona Health Care Cost Containment System (AHCCCS)-assigned member ID number

3 Health Net Group ID – Group number under which the member is enrolled

4 Health Plan Name – Health Net plan in which the member is enrolled

5 Health Net Access Plan Phone – Health Net Member Services telephone number

6 Behavioral Health Service Phone – Telephone number for the Health Net Access behavioral health provider

7 Member Services, Dental Services or Provider Inquiries – Telephone numbers and website address for Health Net Access

8 Physician information - Name, telephone number and address of the member's assigned primary care physician (PCP)

9 Pharmacy information – Contact and claims information or prescription medication processing vendor

10 Submit Medical Claims to – EDI payer ID and address for claim submission

Health Net

Medical Records

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Medical Records Effective 07/01/2013

A physician or other clinician must establish a record at the time of the member's first visit or contact and maintain adequate records throughout the course of the member's medical care. Health Net and its participating providers must maintain books, records, documents, and other evidence of accounting procedures and practices for 10 years. If the member is a child, records must be kept for at least three years after the child's 18th birthday, or for at least six years after the date the child received medical or health care services, whichever occurs last.

All participating providers must comply with applicable state and federal laws, regulations and requirements regarding confidentiality of member medical records. All participating providers are required to implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons.

Health Net has the right to review medical records for the purposes of research for appeals or grievances and for quality and safety of care and services, unless otherwise prohibited by law or a member's express written refusal to permit such access to records. When requested, unless otherwise indicated in the provider's contract, the provider must produce copies of medical records to Health Net at no charge. When a member signs his or her Health Net enrollment form, the signature gives Health Net authorization to obtain certain medical records on the member's behalf. A medical records release form is sent to the physician stating, "Member's Signature on File," when requesting records for appeals and grievances. This statement is valid to obtain medical records on behalf of the member.

Behavioral health records contain information that must not be released as part of the regular medical record and subject to more stringent legal requirements regarding confidentiality. Therefore, when receiving correspondence from a behavioral health clinician, it is recommended that the medical physician keep all behavioral health correspondence in a separate, removable section of the record.

Advance Directives

Found in: Operations Manuals > Medical Records Effective 07/01/2013

Health Net complies with all state and federal laws regarding advance directives. Participating practitioners and providers are required to provide information regarding advance directives to members ages 18 and older to educate them about their rights to create an advance directive. Advance directive education provided to the member, whether a member has executed an advance directive, and the location of the advance directive must be documented in a prominent part of the member's medical record. Health Net monitors medical records to ensure compliance with requirements regarding advance directives.

Annual Medical Record Review

Found in: Operations Manuals > Medical Records Effective 07/01/2013

Health Net has established standards to ensure that medical records are current, detailed and organized, and permit effective, continuous and confidential member care and services.

Primary care physicians (PCPs), OB/GYNs and high-volume specialists are monitored at a minimum of every three years in accordance with the credentialing cycle. Organizational and service providers are monitored annually.

Providers are required to maintain records in an accurate and timely manner in accordance with industry standards and regulatory requirements, and document all care in a manner that meets these standards. In addition, the records should reflect all aspects of member care including past, current and future health status or treatment in order to develop a comprehensive picture of member needs and utilization patterns over time.

The medical record documentation audit tool is a review tool approved by the Quality Management (QM) Committee and used to ensure consistent review. Each element in the review is given a point value. Upon completion of the review, the score is tabulated. The threshold is 85 percent. Scores below 85 percent require corrective action and a subsequent re-audit. Those scoring below the threshold are notified in writing of the results and the need for a corrective action plan. Any results of a re-audit that remain below the threshold of 85 percent are presented for further review and discussion at the QM Peer Review Committee.

The medical record policy, audit tool and guidelines are available by contacting the Health Net Access Quality Management Department.

Changes to PCP

Found in: Operations Manuals > Medical Records Effective 07/01/2013

When a member changes his or her primary care physician (PCP), the current PCP must forward a copy of the member's medical record to the new PCP within 10 business days from the request for transfer.

HIV-Related and Substance Abuse Information

Found in: Operations Manuals > Medical Records Effective 07/01/2013

A release of confidential HIV related information must be signed by the member or a legally-authorized person consenting for the member if the member lacks capacity to consent. A release must be dated and specify to whom disclosure is authorized, the purpose for disclosure and the time period for which the release is effective. A general authorization for the release of medical or other information is not a release of confidential HIV related information unless the authorization specifically indicates its purpose as a general authorization and an authorization for the release of confidential HIV related information and complies with the state requirements.

Health Net requires that all participating providers respect each member's right to confidentiality and treat member information in a respectful, professional and confidential manner consistent with all applicable federal and state requirements. Discussion of member information must be limited to what is necessary to perform the duties of the job. Reports from specialty behavioral health services and consultations are placed in the member's medical record. Behavioral health services are considered confidential and sensitive. Health Net recommends that any written follow-up consultation the PCP receives from the specialist or therapist is placed in a confidential section of the member's medical record.

According to A.R.S. § 36-568.02, a competent adult or emancipated minor may restrict the release of the adult's or the minor's medical or behavioral health records, or both, and information that is otherwise allowable under state and federal law.

Medical Record Elements

Found in: Operations Manuals > Medical Records Effective 07/01/2013

Each participating provider must have in place policies and procedures to ensure member medical records are legible, complete and current. The following are elements that must be noted in all member medical records:

- Member's name or identification (ID) number on each page
- Demographic data
- Initial history
- Past medical history
- Immunization records
- Dental history
- Current problem list
- Current medication list, including dosage, frequency and diagnosis
- Current & complete EPSDT forms
- Documentation of clinical findings and evaluation for each visit
- Laboratory, X-ray and imaging consultant reports initialed and filed
- Advance directives
- Release of information documentation, when applicable
- Continuity of care documentation
- Signed informed consents, when applicable

In lieu of establishing a medical record, behavioral health information, when received from the behavioral health provider about an assigned member, even if the medical provider has not yet seen the assigned member, may be kept in an appropriately labeled file, but must be associated with the member's medical record as soon as one is established.

Medical Record Requests

Found in: Operations Manuals > Medical Records Effective 07/01/2013

Under Arizona 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 to review medical records, the provider must release the records to Health Net. 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 members' medical records to the member in a timely manner in accordance with industry standards.

Release of medical information guidelines must address:

- Requests for personal 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 member chooses a new primary care physician (PCP)
- Availability and accessibility of member medical records to Health Net and to state and federal authorities or their delegates involved in assessing quality of care or investigating enrollee grievances or other complaints
- Availability and accessibility of member medical records to the member in a timely manner in accordance with industry standards 422.118(d)
- Requirements for medical record information between providers of care requesting information from another treating provider as necessary to provide care

Requests by the State or Health Plan

Found in: Operations Manuals > Medical Records Effective 07/01/2013

Arizona Health Care Cost Containment System (AHCCCS) is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. Health Net may obtain a copy of a member's medical record without written approval from the member if the request is directly related to the administration of the AHCCCS program. The medical record must be sent within 20 business days of receipt of request or sooner if necessary.

Written Protocols

Found in: Operations Manuals > Medical Records Effective 07/01/2013

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

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA), 45 CFR 164.530(i)(1) and applicable state law. The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of

PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included
- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)
- Formal system for the availability and retrieval of medical records - allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicaid patients)
- Preventive care guidelines for pediatric (including the use of AHCCCS-approved EPSDT forms) and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every health care provider who creates, maintains, preserves, stores, abandons, or destroys medical records must do so in a manner that preserves the confidentiality of member information and is in compliance with federal and state regulations

Member Rights and Responsibilities

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Member Rights and Responsibilities Effective 10/01/2014

Members have the right to:

- Be treated with respect, and recognition of their dignity and right to privacy
- Not be discriminated against based on race, color, creed, ancestry, national origin, religion, gender, age, intellectual or physical disability, sexual preference, genetic information, marital status, or source of payment
- Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, or visual or auditory limitations
- Select a primary care physician (PCP) from Health Net's participating PCPs, including the right to refuse care from specific providers
- Participate in decision-making regarding their health care, including the right to refuse treatment and have a representative facilitate care or treatment decisions when the member is unable to do so
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the members' conditions and ability to understand the information
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be provided with information about formulating advance directives with his or her health care providers
- Receive information in a language and format that they understand
- Know about providers who speak languages other than English
- Be provided with information regarding grievance, appeals and request for hearing
- Complain about the managed care organization
- Have access to review medical records in accordance with applicable federal and state laws
- Request and receive annually, at no cost, a copy of their medical records
- Receive a response from Health Net Access within 30 days to the members' request for a copy of medical records (response may be the copy of the medical record or written denial, which includes the basis for the denial and information on how to seek review of the denial in accordance with 45 CFR Part 164)
- Amend or correct their medical records
- Freely exercise their rights without adversely affecting their treatment by Health Net Access or associated providers

Members have the responsibility to:

- Provide, to the extent possible, information needed by professional staff to care for the member
- Follow instructions and guidelines given by those providing health care
- Know the name of his or her assigned PCP
- Schedule appointments during office hours whenever possible instead of using urgent care facilities or emergency rooms
- Arrive for appointments on time
- Notify the provider in advance when it is not possible to keep an appointment
- Bring immunization records to every appointment for children ages 18 or younger

Advance Directives

Found in: Operations Manuals > Member Rights and Responsibilities Effective 07/01/2013

Advance directive information (English or Spanish) must be documented in a prominent place in the member's chart, including the date of discussion of an advance directive. Members have the right to make and control their own health care decisions. Health Net is not required to pay for care that is in direct conflict with an advance directive.

Information about advance directives is provided by Health Net in the member's *Evidence of Coverage* (*EOC*) or *Member Handbook*, which is updated annually. The *EOC* or *Member Handbook* includes the following information:

- Advance directives are written instructions prepared or completed by members that advise the member's family, friends and physicians what the member wants done in case of serious injury or illness causing them to be unable to speak for themself
- Participating providers must honor any member's advance health care directive in accordance with federal and state laws. Health Net does not condition the provision of coverage or discriminate against a member based on whether or not he or she has executed an advance directive

If the member has completed a living will or health care power of attorney, he or she is responsible for delivering it directly to his or her primary care physician (PCP), to be placed in the member's medical record.

Americans with Disabilities Act of 1990

Found in: Operations Manuals > Member Rights and Responsibilities Effective 07/01/2013

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

Member Confidentiality

Found in: Operations Manuals > Member Rights and Responsibilities Effective 06/01/2009

Participating providers must respect each member's right to confidentiality. Providers are expected to treat member information in a respectful, professional and confidential manner that is consistent with all applicable federal and state requirements. Confidentiality is the principle that member information and medical records are protected against unlawful disclosure and that those with access to member information and medical records do not share such information inappropriately.

Notice of Non-Discrimination

Found in: Operations Manuals > Member Rights and Responsibilities Effective 11/11/2014

When Health Net makes decisions about employment of staff or provides health care services, it does not discriminate based on a person's race, disability, religion, sex, sexual orientation, ethnicity, creed, age, national origin, or any factor that is related to health status, including, but not limited to the following:

- Medical condition, including behavioral, as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Additionally, the participating provider must have practice policies that demonstrate that he or she accepts for treatment any member in need of the health care services that are offered by the provider.

Health Net 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 Medicaid, including Health Net 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.

Primary Care Physician Assignment

Found in: Operations Manuals > Member Rights and Responsibilities Effective 05/12/2016

Selection Criteria

Member assignment is based on the member's choice and auto-assignment; therefore, Health Net Access does not guarantee that a provider will receive a set number of members. Members reserve the right to select another primary care provider (PCP) after initial assignment and anytime thereafter. Health Net Access auto-assigns PCPs to new members enrolled in the Health Net Access plan using the following process:

- PCPs are located within 10 miles of the member's residence, which is broadened in five-mile increments, if necessary, until a PCP is located.
- PCPs must not have reached Health Net Access's maximum capacity.
- Members under ages 12 are assigned to a pediatrician.
- Members under ages 18 are not assigned to an internal medicine PCP.
- New members under age 18 who share the same case number as an existing Health Net Access member under age 18 are assigned to the same PCP regardless of the maximum capacity designated by Health Net Access.
- Members who are currently in Health Net's Medicare Advantage Special Needs Plan are assigned to the same PCP, when possible, if the PCP is registered with Arizona Health Care Cost Containment System (AHCCCS).
- Members previously enrolled with Health Net Access are assigned to the same PCP if the member was dis-enrolled for less than 90 calendar days.

Member Capacity

PCPs must follow the below guidelines regarding member capacity:

- The PCP must contact his or her Health Net Access Services representative if he or she declared a specific member capacity for his or her practice and want to make a change to that capacity.
- The PCP must not refuse to treat members as long as the PCP has not reached requested member capacity.
- Providers must notify Health Net Access at least 45 days in advance of their inability to accept additional Medicaid members.

Health Net Access prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

Health Net Access mails a member identification (ID) card to the member after the PCP is assigned.

Welcome Kit

Health Net Access mails a welcome letter and *Member Handbook to* new members or their families, as applicable. Additionally, Health Net Access sends a PCP notice letter to new members detailing the PCP's contact information and how to request a PCP change. These letters are mailed within 12 business days following Health Net Access' receipt of the enrollment file from AHCCCS.

Second Opinion

Found in: Operations Manuals > Member Rights and Responsibilities Effective 07/01/2013

Health Net Access members have the right to seek a second opinion for diagnosis and treatment at no cost from a qualified health care provider in or out of Health Net's participating provider network. Prior authorization is required to access a non-participating provider.

The Advance Directive - Spanish

Health Net®

La Instrucción Previa

Una instrucci n previa por escrito es un documento legal que informa sobre el tipo de cuidado de la salud y de tratamiento que usted prefiere. Además, proporciona el nombre de la persona que tomará las decisiones por usted en caso de que usted ya no pueda tomar decisiones sobre el cuidado de su salud. Esta persona también se llama agente. Cualquier adulto mayor de 18 a os tiene derecho a hacer una instrucci n previa.

Por qué es importante
La instrucci n previa puede darle mucha tranquilidad en caso de que usted ya no pueda tomar decisiones sobre la atenci n de su salud, ya sea a causa de una enfermedad o una lesi n. Los beneficios incluyen los siguientes:

- Podrá asegurarse de que obtendrá los cuidados y servicios que desea.
- Podrá rechazar un tratamiento en un punto determinado de su enfermedad o afecci n.
- Podrá indicar el nombre de su agente para que tome las decisiones del cuidado de su salud cuando usted ya no pueda expresar su voluntad.

Si usted no explica su voluntad de manera clara, su familia podrá tomar esas decisiones por usted. Si ellos no llegan a un acuerdo sobre el tipo de tratamiento, esto podría resultar en indecisi n y en un posible retraso legal.

Quién "puede" y quién "no puede" tomar estas decisiones
Su agente puede ser un familiar o un amigo, pero no podrá ser su médico. El agente podrá tomar todas las decisiones sobre el cuidado de su salud en su nombre si usted pierde la capacidad de expresar su voluntad. Su agente podrá decidir si rechazar o detener los tratamientos de manutenci n de vida si usted le da la autoridad. Algunos ejemplos de tratamientos de manutenci n de vida son: alimentaci n por sonda, manutenci n de la vida con asistencia respiratoria o diálisis renal.

Déjelo asentado por escrito
No necesita un abogado para completar una instrucci n previa. La instrucci n previa por escrito debe estar firmada por dos testigos. Estos testigos no podrán ser su médico, su enfermera ni otro profesional para el cuidado de la salud.

Para preparar una instrucci n previa, usted debe incluir la siguiente informaci n:

- Instrucciones acerca de sus deseos con respecto al tratamiento médico, incluido cuándo rechazar o aceptar tratamientos de manutenci n de vida.
- El nombre completo, la direcci n y los n meros de teléfono de contacto del agente que usted elija para que tome las decisiones del cuidado de salud en su nombre cuando usted ya no pueda tomar dichas decisiones.
- Dos testigos deberán firmar este aviso e incluir sus nombres completos, direcciones y n meros de teléfono.

Health Net®

Estar preparado con una instrucci n previa le brinda opciones para decidir qué tipos de tratamientos desea recibir y quién debe hablar por usted cuando no pueda expresarse por sus propios medios. Usted también puede entregar copias a su médico, a sus familiares y a la instituci n donde es probable que lo internen.

La informaci n que se proporciona no debe reemplazar al asesoramiento médico ni a la atenci n médica profesional. Siempre recurra al asesoramiento de su médico u otro proveedor de salud por cualquier inquietud que tenga con respecto a su condici n médica y siga las instrucciones de su proveedor de cuidado de la salud.

Health Net es una organizaci n de Medicare Advantage que tiene contrato con Medicare. La informaci n sobre beneficios provista es un breve resumen y no constituye una descripci n completa de los beneficios disponibles. Para obtener más informaci n, comuníquese con el plan. Pueden aplicarse limitaciones, copagos y restricciones. Los beneficios pueden cambiar el 1.º de enero de cada a o.
Health Net of California, Inc., Health Net of Arizona, Inc., Health Net Health Plan of Oregon, Inc. y Health Net Life Insurance Company son subsidiarias de Health Net, Inc. Health Net es una marca de servicio registrada de Health Net, Inc. Todos los derechos reservados.

N.º de identificaci n del material Y0035_2012_1173_SPN (H0351, H0562, H5439, H5520, H6815, EG) Cumplimiento aprobado 10092012

The Advance Directive

Health Net®

The Advance Directive

A written advance directive is a legal document that communicates what type of health care and treatment you prefer. It also provides the name of the person who will speak for you, also known as your agent, if you can no longer make decisions about your own health care. Any adult age 18 or older has the right to create an advance directive.

Why it's important
In the event you can no longer make health care decisions for yourself, either because of an illness or injury, an advance directive can offer great peace of mind. Benefits include:

- Making sure you get the care and services you want.
- Allowing you to refuse treatment at a certain point in your illness/condition.
- Providing the name of your agent to make health care decisions for you when you can no longer express your wishes.

If you do not make your wishes clear, your family could make these decisions for you. If they do not agree on the type of treatment, a disagreement may lead to indecision and possible legal delay.

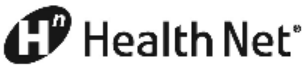
Who "can" and "cannot" make these decisions
Your agent may be a family member or friend, but cannot be your attending doctor. The agent can make any and all health care decisions for you if you become unable to express your wishes. Your agent can decide to refuse or stop life-sustaining procedures if you give the agent this authority. Examples of life-sustaining procedures include tube feeding, being kept alive with a breathing machine, or kidney dialysis.

Get it in writing
You do not need an attorney to complete an advance directive. The written advance directive must have signatures of two witnesses. These witnesses cannot be your doctor, nurse or other health care professional.

To prepare an advance directive, include the following information:

- Instructions about your wishes for medical treatment, including when to refuse or accept life-sustaining procedures.
- The full name, address and contact telephone numbers of the agent you choose to make health care decisions on your behalf when you reach a point where you can no longer make decisions for yourself.
- Two witnesses must sign this notice and include their full names, addresses and telephone numbers.

Being prepared with an advance directive gives you choices to decide what types of treatments you want and who you want to speak for you when you cannot speak for yourself. You may also give copies to your doctor, family members and any facility where you are likely to be admitted.



Material ID #Y0035_2012_1173 (H0351, H0562, H5439, H5520, H6815, EG) Compliance Approved 10092012

Prescription Drug Program

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Prescription Drug Program Effective 05/16/2016

Health Net offers a prescription medication program with comprehensive medication coverage. The *Health Net Access Drug List* was developed by the Pharmacy and Therapeutics (P&T) Committee, with involvement and recommendations from physicians, pharmacists and other health care professionals. Development and maintenance of the *Health Net Access Drug List* is a detailed and ongoing process. The *Health Net Access Drug List* is continually reviewed and revised in response to recommendations from participating providers, and as new scientific and clinical data and pharmaceuticals become available. Therapeutic needs and cost-effectiveness are also considered when adding or removing medications from the *Health Net Access Drug List*.

The *Health Net Access Drug List* only applies to outpatient prescription medications. It does not apply to inpatient medications (received in a hospital, skilled nursing facility or nursing home) or to medications obtained from or administered by a health care professional.

Self-injectable medications are available through Health Net Access outpatient prescription medication benefits. Most self-injectable medications, except preferred insulins in vials, require prior authorization.

Select medications, including both brand-names and generics, may require prior authorization. Prior authorization is required for medications not listed on the *Health Net Access Drug* List. To request medication prior authorization, complete the Prior Authorization/Formulary Exception Request Fax Form. Quantity limits may apply to medications obtained at a participating

pharmacy. Members may refer to their plan documents or the *Health Net Access Drug List* for specific limitations.

Diabetic Supplies

Diabetic supplies are limited to a one-month supply (to the nearest package size) with a prescription.

Exclusions

The following items, by way of example, are not reimbursable:

- Drug efficacy study implementation (DESI) medications (those considered less than effective by the Food and Drug Administration (FDA)).
- Non-FDA approved agents.
- Any medication limited by federal law to investigational use only.
- Medications used for cosmetic purposes.
- Medications for erectile dysfunction.
- Medications used to increase fertility.

For more information regarding pharmacy benefits, contact the Health Net Access Provider Services Center.

Generic Substitutions

Found in: Operations Manuals > Prescription Drug Program Effective 05/16/2016

Health Net Access and its participating providers must utilize a mandatory generic medication substitution policy that requires the use of a generic equivalent medication whenever one is available. The exceptions to this requirement are as follows:

- A brand-name medication may be covered when a generic equivalent is available when Health Net Access' negotiated rate for the brand-name medication is equal to or less than the cost of the generic medication.
- AHCCCS may require Health Net Access to provide coverage of a brand-name medication when the cost of the generic medication has an overall negative financial impact to the state of Arizona. The overall financial impact to the state includes consideration of the federal and supplemental rebates.

Prescribing providers must clinically justify the use of a brand-name medication over the use of its generic equivalent through the prior authorization process.

Health Net Access Drug List

Found in: Operations Manuals > Prescription Drug Program Effective 09/13/2016

The *Health Net Access Drug List* identifies the medications, selected by the Pharmacy and Therapeutics (P&T) Committee, that are clinically appropriate to meet the therapeutic needs of members in a cost effective manner. The *Health Net Access Drug List* is developed, reviewed and updated monthly, as necessary by the P&T Committee. Medications are added or removed based on objective, clinical and scientific data. Considerations include efficacy, side-effect profile, and cost and benefit comparisons to alternative agents, if available. At a minimum, the *Health Net Access Drug List* includes all medications on the AHCCCS Drug List. Additional medications may also be included.

Key considerations for the *Health Net Access Drug List* are as follows:

- Preferred medications on the AHCCCS Drug List for specific therapeutic classes
- To view or to print a hard-copy of the AHCCCS Drug List, go to www.azahcccs.gov/Resources/GuidesManualsPolicies/pharmacyupdates.html.
- Therapeutic advantages outweigh cost considerations in all decisions to change medications on the *Health Net Access Drug List*. Market-share shifts, price increases, generic availability, and varied dosage regimens may affect the actual cost of therapy.
- Products are not added to the *Health Net Access Drug List* if there are less expensive, similar products on the formulary.
- When a medication is added to the *Health Net Access Drug List*, other medications may be removed.
- Participating physicians may request additions or deletions for consideration by the P&T Committee. Requests should include the following:
    - Basic product information, indications for use and its therapeutic advantage over medications currently on the list.
    - Which medication(s), if any, the recommended medication would replace in the current *Health Net Access Drug List*.
    - Any published supporting literature from peer-reviewed medical journals

Health Net Access may invite the requesting physician to the P&T Committee to support the addition to the *Health Net Access Drug List* and answer related questions. Health Net Access does not permit pharmaceutical representatives to participate in or attend P&T Committee meetings. All requests for additions to the *Health Net Access Drug List* should be sent to the Health Net Access Pharmacy Department.

Prescription medications may be prescribed by any authorized provider, such as a primary care provider (PCP), attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed.

The *Health Net Access Drug List* is available electronically on the Health Net provider website at www.healthnetaccess.com under *Pharmacy Information* > *Pharmacy Information Overview* > *Drug Lists*. Providers can request a printed version of the *Health Net Access Drug List* by calling the Health Net Access Provider Services Center.

For more information regarding pharmacy benefits, contact the Health Net Access Provider Services Center.

Notification of Formulary Updates

Health Net Access provides 60-day advance notice to affected members and their prescribing providers of medication removal from the *Health Net Access Drug List* to allow time to prescribe an alternative medication.

Health Net Access is not required to send a hard copy of the *Health Net Access Drug List* each time it is updated, unless requested. Health Net Access notifies members and providers of updates and changes and may refer providers to view the updated *Health Net Access Drug List* on the Health Net Access website. Providers and members may request a printed version of the *Health Net Access Drug List* by calling Member Services.

Prior Authorization Requirements

Found in: Operations Manuals > Prescription Drug Program Effective 05/16/2016

Prior authorization may be required as follows:

- If the medication is not included on the *Health Net Access Drug List.*
- If the prescription requires compounding.
- For injectable medications dispensed by a pharmacy, with the exception of insulins on the *Health Net Access Drug List.*
    - Note: If the member has a primary health plan that reimburses for injectable medications, Health Net Access will only coordinate benefits as the secondary payer if the Health Net Access pharmacy prior authorization process was followed.
- For injectable medications requiring prior authorization dispensed by the physician and billed through the member's health plan, call Health Net Access Pharmacy Department at 1-800-410-6565 to initiate prior authorization for the requested specialty medication.
- For medication quantities that exceed recommended doses.
- For specialty medications that require certain established clinical guidelines be met before consideration for prior authorization.
- For certain medications that may require additional documentation.

Allow up to 14 calendar days for the prior authorization review process.

In instances where a prescription is written for medications not on the *Health Net Access Drug List*, the pharmacy may contact the prescriber to either request an alternative or to advise the prescriber that prior authorization is required for non-covered medications.

Prior authorization requests submitted for review must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited, to the following:

- Food and Drug Administration (FDA)-approved indications and limits.
- Published practice guidelines and treatment protocols.
- Comparative data evaluating the efficacy, type and frequency of side effects and potential medication interactions among alternative products as well as the risks, benefits and potential member outcomes.
- Drug facts and comparisons.
- American Hospital Formulary Service Drug Information.
- United States Pharmacopeia drug information.
- DRUGDEX Information System.
- UpToDate®, an evidence-based clinical decision support resource
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies.

A non-FDA indication may not be the sole basis of denial, as off-label prescribing may be clinically appropriate as outlined above. Prescribing providers must submit a prior authorization request to Health Net Access for review and coverage determination.

Smoking Cessation Therapy

Found in: Operations Manuals > Prescription Drug Program Effective 03/20/2015

Health Net Access covers nicotine replacement therapy (NRT) (such as nicotine transdermal patches), Zyban® or Chantix™, for members ages 18 or older, subject to formulary limitations. The maximum a member may receive of a tobacco cessation product is a 12-week supply in a six-month time period, which begins on the date the pharmacy fills the first tobacco cessation product. A prescription from the primary care physician (PCP) is required for coverage of tobacco cessation products, including over-the-counter (OTC) products.

Health Net Access encourages members to enroll in the Health Net Access's Arizona Smokers' Helpline (ASHLine) program, which offers a variety of options to members to help them quit smoking and stay tobacco-free.

Prior Authorization

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Prior Authorization Effective 09/14/2016

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. To ensure a complete review, Health Net Access may request additional documentation to substantiate whether the requested service meets Health Net Access criteria. Prior authorization does not guarantee payment. Reimbursement is based on the accuracy of the information received with the prior authorization request, on whether or not 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. Obtaining prior authorization is the provider's responsibility; the member must not be billed if the provider fails to obtain prior authorization before performing services.

When Health Net Access is the member's secondary coverage, no prior authorization is required; however, Health Net Access determines whether a requested service meets the criteria for medical necessity when the primary carrier denies a service for lack of medical necessity. Health Net Access covers the requested service after medical necessity is determined.

Emergency Services

Found in: Operations Manuals > Prior Authorization Effective 09/14/2016

Health Net Access provides coverage for emergency services to all members. An emergency medical condition is defined as the treatment for a medical condition, including emergency labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services are covered both in-network and out-of-network and do not require prior authorization. In accordance with the Arizona Health Care Cost Containment Systems (AHCCCS) and 42 CFR 438.114, emergency room screening and stabilization services do not require prior authorization to be covered by Health Net Access. Refer to the Emergency Services section for additional information.

Non-Delegated Medical Group/IPA Denials

Found in: Operations Manuals > Prior Authorization Effective 07/01/2013

Medical groups and independent practice associations (IPAs) that are not delegated for denial determinations must notify Health Net of all potential authorization denials. The prior authorization request and pertinent documentation must be faxed to the Health Net Prior Authorization Department (HMO and Medicare Advantage HMO or Health Net Access) within one business day.

Prescription Medication Prior Authorization Requests

Found in: Operations Manuals > Prior Authorization Effective 07/01/2013

Some in-office injectables and medications listed on the Health Net Access Drug List may require prior authorization. Physician or pharmacy 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.

Prior Authorization Process

Found in: Operations Manuals > Prior Authorization Effective 09/14/2016

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 coverage of benefit 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 (www.guidelines.gov) as approved by the Medical Practice Committee and the Quality Council
- Arizona Health Care Cost Containment Systems (AHCCCS) Medical Policy Manual content

Health Net's national medical and behavioral health policies are reviewed at least annually with input from network practitioners and updated as necessary, and are available on the Health Net Access provider website at www.healthnetaccess.com.

Medical directors are always available to discuss prior authorization requests and denials with the requesting physician. They can be reached by contacting the Prior Authorization Department. The denial letter includes criteria used in a decision that results in a denial determination (Notice of Action) and an explanation of the appeal process. A copy of the criteria utilized in the decision can be obtained upon request and all criteria are available for review at the Health Net Access office.

Utilization management decisions are based on appropriateness of care and service and the eligibility of coverage. 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.

Prior Authorization Responses

Found in: Operations Manuals > Prior Authorization Effective 07/01/2013

Upon receipt of all necessary information, Health Net processes all routine requests within 14 calendar days. Expedited requests are turned around within three business days of the receipt of the request. If Health Net 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 medically necessary criteria, a letter is automatically sent to the member and the requesting physician, and the primary care physician (PCP), if applicable, for all denied service requests. The letter includes an explanation of how a copy of the criteria utilized in the decision can be obtained and an explanation of the appeal process. The physician may discuss the case with a medical management reviewer or physician reviewer by contacting the Health Net Prior Authorization Department.

Participating providers and their staff are prohibited from giving Health Net members verbal denials. All requests, regardless of coverage, must be processed.

Requesting Prior Authorization

Found in: Operations Manuals > Prior Authorization Effective 10/01/2015

Completion of the Health Net Access Request for Prior Authorization form is the primary method used by Health Net to manage the referral process for providers directly contracting with Health Net. It enables Health Net to monitor the care provided to members and provides instructions to the specialist regarding authorized services.

Prior Authorization requests for dual-eligible General Mental Health and Substance Abuse (GMHSA) members should be submitted to the Health Net Prior Authorization Department. Prior authorization requests for Health Net Access only members (non- dual-eligible) behavioral health and substance abuse services must be referred to the Regional Behavioral Health Authority (RBHA). If coordination assistance with RBHA is needed, contact the Health Net Access Member Services Department.

When faxing a prior authorization request, attach pertinent medical records, treatment plans, test results, and evidence of conservative treatment to support the medical appropriateness of the request.

Guidelines for Referrals

Primary care physicians (PCPs) and specialists should follow the guidelines below when completing the Health Net Access Request for Prior Authorization form to request prior authorization of services. Providers are required to complete all fields within the form to expedite processing of prior authorization requests.

- If the number of units or visits is not indicated in the Professional field, only one visit is authorized by Health Net. That visit must take place within 60 days of the order date. If more than one consultation is required, another request must be submitted to Health Net for review.
- Select the product line (Health Net Access). This field assists the Health Net Prior Authorization Department in determining the sets of prior authorization guidelines as it varies by product line.
- Designate the type of request (urgent or elective).
- Designate service requested to determine prior authorization requirements.
- The "From" provider information refers to who is requesting the prior authorization for services. The "To" provider information refers to where the services will be rendered. A PCP or specialist can be the "From" provider information.
- ICD-10 and CPT codes as well as descriptions are required fields.
- Requesting providers (PCPs or specialists) must sign the Request for Prior Authorization form.
- Providers need to attach all pertinent medical information in order for the request to be reviewed for medical necessity.

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

Prior Authorization Requirements

Based on medical necessity, the services, procedures and equipment listed in the Prior Authorization Requirements - Health Net Access require prior authorization.

Behavioral Health Services Not Requiring Prior Authorization

Authorization is not required for some 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

Health Net Access Prior Authorization Requirements

Effective: July 1, 2016

Health Net Access

Arizona

Prior Authorization Requirements

Health Net Access, Inc.

The following services, procedures and equipment are subject to prior authorization requirements (unless noted as notification required only). When faxing a request, please attach pertinent medical records, treatment plans, test results, and evidence of conservative treatment to support the medical appropriateness of the request. All services are subject to benefit plan coverage limitations, members must be eligible, and medical necessity must exist for any plan benefit to be a covered service irrespective of whether or not prior authorization is required.

Providers should refer to Health Net Access **prior authorization limitations and exclusions** on page 4 for additional information. Unless noted differently, all services listed below require prior authorization from Health Net Access. Refer to page 5 for submission information and **prior authorization contacts**.

INPATIENT SERVICES[1]	COMMENTS
Acute rehabilitation facility	
Behavioral health or detoxification	• applies to dual eligible members only* • includes hospital, psychiatric hospital, subacute facility, and residential treatment center or related bed holds
Hospice facility	
Hospital facility	
Newborns – births (including stillborn and unexpected deaths) within 12 hours of delivery	• Providers must complete and submit the Newborn Reporting Form, in conjunction with the Health Net prior authorization request, by secure fax to the **Health Net Hospital Notification Unit.** • The Newborn Reporting Form is available in the *Forms* section of the Provider Library on the Health Net provider website at provider.healthnet.com.
Nursing facility/skilled nursing facility	
Observation services	**Notification required only if less than 24 hours. If greater than 24 hours, authorization is required;** contact the **Health Net Hospital Notification Unit**
Urgent/emergent admission	**Notification required only** as soon as possible, but no later than 24 hours or by the next business day; contact the **Health Net Hospital Notification Unit**

*Dual eligible members are members who are eligible and enrolled for coverage through Medicare and Medicaid. Dual eligible members have access to behavioral services through Health Net Access. 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.

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
All non-contracted and out-of-state services	
Ambulance	Applies to non-emergency fixed wing air transportation
Back/spinal surgery	Includes laminotomy, diskectomy, vertebroplasty, and nucleoplasty
Bariatric-related services	Surgical procedure
Blepharoplasty	Surgical procedure
Breast implants removal	Surgical procedure
Breast reconstruction	Surgical procedure
Breast reduction and augmentation	Surgical procedure
Chondrocyte Implants	
Cleft palate reconstructive surgery, including dental and orthodontic services	Surgical procedure
Clinical trials	
Cosmetic services, evaluation and procedure	
Custom orthotics	
Dental	Dental procedure covered by medical benefit requires PA. Contact **Dental Benefit Providers for all other dental services.**
Dermatology	Procedure Including but not limited to: • chemical exfoliation and electrolysis • dermabrasion/chemical peel • laser treatment • skin injections and implants
Electroconvulsive therapy (ECT)	Applies to dual eligible members only*
Genetic testing	
Durable medical equipment (DME) (see pre-authorization tool for guidance)	
Enteral/parenteral/medical foods services and supplies	
Experimental/investigational services and new technologies	Includes, but is not limited to, those listed in the *Investigational Procedures List* located on the Health Net provider website at provider.healthnet.com > *View our Medical Policies > Investigational Procedure List.*
Home health services	
Hospice/palliative care	
Hyperbaric oxygen therapy	
Intensity modulated radiation therapy (IMRT)	

*Dual eligible members are members who are eligible and enrolled for coverage through Medicare and Medicaid. Dual eligible members have access to behavioral services through Health Net Access. 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.

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT, CONTINUED	COMMENTS
Maternity	• Prior authorization is required at the time of first prenatal visit. The authorization will apply to the total obstetrical care date range Providers are required to identify risk factors by completing a comprehensive tool that covers psychosocial, nutritional, medical, and educational factors (such as the American Congress of Obstetricians and Gynecologists (ACOG) or Mutual Insurance Company of Arizona (MICA) assessment tools). • Providers are required to submit the risk factor assessment, such as the ACOG or MICA assessment tool, in conjunction with the Health Net Request for Prior Authorization form, when requesting prior authorization. o The Health Net Access Request for Prior Authorization form available in the *Forms* section of the Health Net Access website at www.healthnetaccess.com.
Neuro or spinal cord stimulators	-
Neuropsych testing	
Orthognathic procedures (including TMJ treatment)	Surgical procedure
Outpatient diagnostic procedures	Contact **eviCore healthcare** for the following procedures: • computed tomography (CT) • magnetic resonance angiography (MRA) scans • magnetic resonance imaging (MRI) scans • nuclear cardiac imaging procedures • positron emission tomography (PET)
Outpatient physical, occupational, and speech therapy	**Rehabilitative and habilitative services**
Perinatology referral and care	**Notification required only**
Posterior tibial neuro stimulation/pelvic floor stimulation	Surgical procedure
Pregnancy termination	Surgical procedure
Prosthetics (see pre-authorization tool for guidance)	-
Proton beam therapy	-
Psychological testing	Applies to dual eligible members only*
Rhinoplasty	Surgical procedure
Septoplasty	Surgical procedure
Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)	
Sterilization	Surgical procedure
Transplant-related services, including evaluation	-
Treatment of varicose veins	Surgical procedure
Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP	Surgical procedure
X-Stop	Surgical procedure

*Dual eligible members are members who are eligible and enrolled for coverage through Medicare and Medicaid. Dual eligible members have access to behavioral services through Health Net Access. 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.

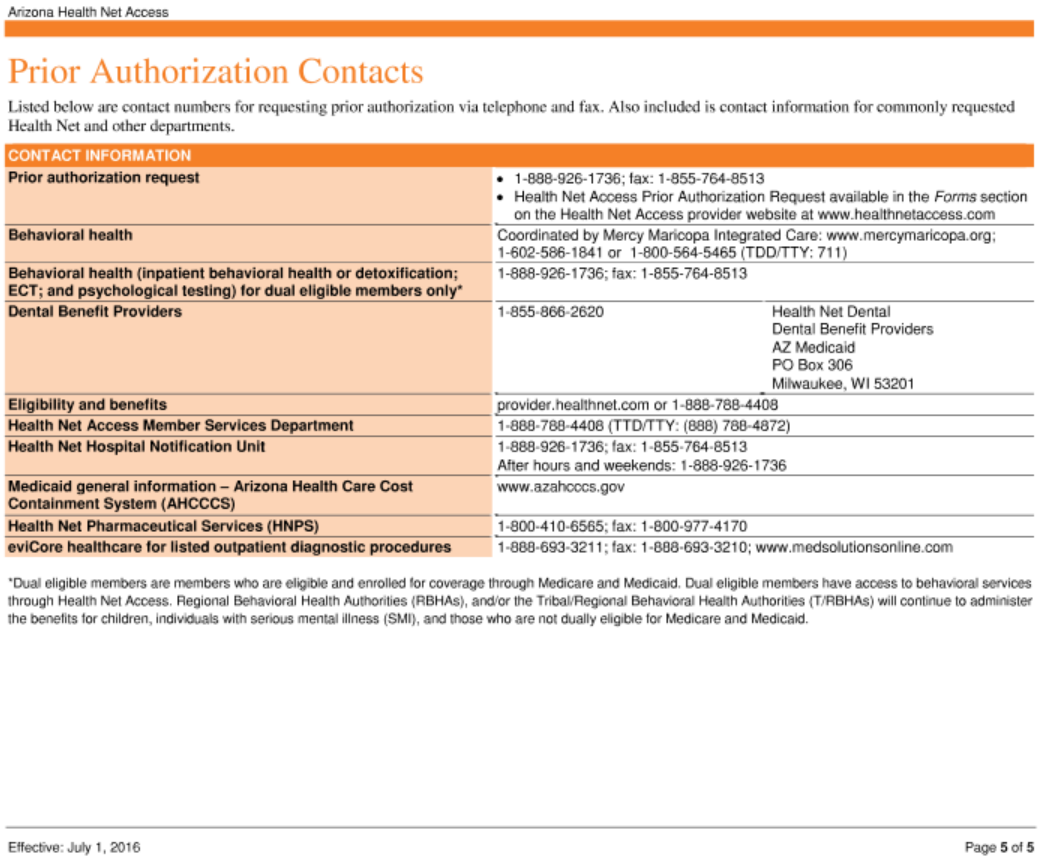
OUTPATIENT PHARMACEUTICALS (SUBMITTED UNDER MEDICAL BENEFIT)			COMMENTS
Hemophilia factors			Prior authorization required from **HNPS**
Self-injectables			Prior authorization required from **HNPS**
• **Actemra®** • **Aldurazyme®** • **Aralast®** • **Aranesp®** • **Benlysta®** • **Botox®** • **Cerezyme®** • **Cinryze®** • **Cosentyx®** • **Dysport®** • **Entyvio™*** • **Fabrazyme®** • **Flolan®** • **Glassia™** • **H.P. Acthar® Gel**	• **Ilaris®** • **Immune globulin Krystexxa®** • **Lemtrada®** • **Lucentis®** • **Lumizyme®** • **Makena™** • **Myobloc®** • **Myozyme®** • **Naglazyme®** • **Nplate®** • **Orencia®** • **Prolastin®** • **Provenge®** • **Remicade®**	• **Remodulin®** • **Rituxan® (non-oncology only)** • **Simponi® Aria™** • **Soliris®** • **Stelara®** • **Synagis®** • **Tysabri®** • **Ventavis®** • **Vpriv™** • **Xeomin®** • **Xiaflex®** • **Xolair®** • **Zemaira®**	• Prior authorization required from **HNPS** • Immune globulin examples: intravenous immunoglobulin (IVIG), Hizentra®, HYQVIA

*Dual eligible members are members who are eligible and enrolled for coverage through Medicare and Medicaid. Dual eligible members have access to behavioral services through Health Net Access. 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.

Prior Authorization Limitations and Exclusions

Listed below are prior authorization limitations and exclusions, and sensitive, confidential or other services that do not require prior authorization for Health Net Access members.

- Authorizations for Children's Rehabilitation Services (CRS)-eligible conditions for members under age 21 and enrolled in CRS require prior authorization from CRS. Contact CRS at 1-866-275-5776 or by email at CRS_SpecialNeeds@uhc.com
- Routine laboratory services must be performed at participating facilities
- Authorization requests for behavioral health and substance abuse services for children, individuals with serious mental illness (SMI) and those who are not dually eligible for Medicare and Medicaid must be referred to RBHAs/TRBHAs. If coordination assistance with RBHAs/TRBHAs is needed, contact the Health Net Access Member Services Department. For dual eligible non-SMI members, behavioral health and substance abuse services are excluded.
- Emergency room (ER) services after stabilization of an emergency medical condition or when the medical screening exam (MSE) does not demonstrate an emergency medical condition are subject to review by Health Net and may not be paid



Arizona Health Net Access

Prior Authorization Contacts

Listed below are contact numbers for requesting prior authorization via telephone and fax. Also included is contact information for commonly requested Health Net and other departments.

CONTACT INFORMATION		
Prior authorization request	• 1-888-926-1736; fax: 1-855-764-8513 • Health Net Access Prior Authorization Request available in the *Forms* section on the Health Net Access provider website at www.healthnetaccess.com	
Behavioral health	Coordinated by Mercy Maricopa Integrated Care: www.mercymaricopa.org; 1-602-586-1841 or 1-800-564-5465 (TDD/TTY: 711)	
Behavioral health (inpatient behavioral health or detoxification; ECT; and psychological testing) for dual eligible members only*	1-888-926-1736; fax: 1-855-764-8513	
Dental Benefit Providers	1-855-866-2620	Health Net Dental Dental Benefit Providers AZ Medicaid PO Box 306 Milwaukee, WI 53201
Eligibility and benefits	provider.healthnet.com or 1-888-788-4408	
Health Net Access Member Services Department	1-888-788-4408 (TTD/TTY: (888) 788-4872)	
Health Net Hospital Notification Unit	1-888-926-1736; fax: 1-855-764-8513 After hours and weekends: 1-888-926-1736	
Medicaid general information – Arizona Health Care Cost Containment System (AHCCCS)	www.azahcccs.gov	
Health Net Pharmaceutical Services (HNPS)	1-800-410-6565; fax: 1-800-977-4170	
eviCore healthcare for listed outpatient diagnostic procedures	1-888-693-3211; fax: 1-888-693-3210; www.medsolutionsonline.com	

*Dual eligible members are members who are eligible and enrolled for coverage through Medicare and Medicaid. Dual eligible members have access to behavioral services through Health Net Access. 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.

Effective: July 1, 2016 Page 5 of 5

Product Description

Found in: Operations Manuals Effective 01/01/2003

Health Net Access

Found in: Operations Manuals > Product Description Effective 09/13/2016

The Arizona Health Care Cost Containment System (AHCCCS) administers the state's Medicaid managed care programs. Health Net is a contractor for AHCCCS and offers Health Net Access, Health Net's Medicaid managed care program in Maricopa County. Medicaid managed care differs from commercial managed care in that it integrates private health care with publicly funded health programs.

Health Net Access sends members Health Net Access identification (ID) cards that members use in place of the state Medicaid card to receive covered services from Health Net Access participating providers. Members select a primary care provider (PCP) to provide primary care services and coordinate medically necessary specialty care; however, members may access some covered services, such as family planning services, without referral or prior authorization from their PCPs or Health Net Access.

Medical care is provided to Health Net Access members through private physicians practicing individually or together in multispecialty medical groups.

Provider Oversight

Found in: Operations Manuals Effective 01/01/2003

Advertising

Found in: Operations Manuals > Provider Oversight Effective 07/01/2013

All advertising bearing any Health Net name, mark or logo must by approved by the Arizona Department of Insurance (ADOI) or Arizona Health Care Cost Containment System (AHCCCS) before use. The Centers for Medicaid and Medicare Services (CMS) and accreditation entities have additional restrictions and requirements. Providers must submit any advertising bearing a Health Net name, mark or logo to Health Net prior to use in order to secure regulatory approval.

After-Hours Template

Found in: Operations Manuals > Provider Oversight Effective 07/01/2013

Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has designed an after-hours script template that providers who have a centralized triage service or other answering service can use as a guide for staff answering the telephone. For physicians or providers who use an automated answering system/answering machine, this template can be used as a script to advise members on how to access care. The script includes basic information that members need to access after-hours care. The appropriate time frame should be modified, as applicable, according to each line of business.

Health Net makes the script available in the following threshold languages:

Chinese/Cantonese

English

Spanish

Contact the Health Net Quality Improvement Department or Quality Managment Department for more information on the script templates.

Appointment Accessibility Standards

Found in: Operations Manuals > Provider Oversight Effective 10/01/2015

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

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

Type of Care		**Accessibility Standard**
Primary Care		
	Emergency	Same day or within 24 hours of member's call
	Urgent care	Within 2 days of request
	Routine	Within 21 days of request
Specialty Referral		
	Emergency	Within 24 hours of referral
	Urgent care	Within 3 days of referral
	Routine	Within 45 days of referral
Maternity		
	1st trimester	Within 14 days of request
	2nd trimester	Within 7 days of request
	3rd trimester	Within 3 days of request
	High-risk pregnancies	Within 3 days of identification
Dental		
	Emergency	Within 24 hours of request
	Urgent care	Within 3 days of request
	Routine	Within 45 days of request

The wait time in the office must be 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	Within 2 hours - may include telephonic or face-to-face interventions

	later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical	
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		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: 1. The member does not run out of any needed psychotropic medications; or 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.
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		Member must not arrive sooner than one hour before his or her scheduled appointment; and Member must not have to wait for more than one hour 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

After-Hours Access 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 *Provider Participation Agreement* (*PPA*), Health Net 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 back-up 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 instruction on 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 per 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.

Answering Services

The provider is responsible for the answering service he or she uses. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room." If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is liable for authorization of, or referral to, emergency care given by the answering service. After office hours (outside of normal business hours or when the offices are closed) physicians are required to return calls and pages within four hours. If the member indicates a need to speak with the physician or calls for an urgent matter, PCPs or on-call physicians should return telephone calls and pages within four hours and be available 24 hours a day, seven days a week.

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional. Answering services frequently have high staff turnover, so providers should monitor the answering service to be sure that it follows emergency procedures.

Health Net encourages answering services to follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
- Question the member according to the PCP's or medical group's established instructions (who, what, when, and where) to assess the nature and extent of the problem and offer interpreter services assistance as needed.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, the on-call physician must return telephone calls and pages within four hours. If an on-call physician cannot be reached, direct the member to a medical facility where he or she can receive emergency or urgent care treatment. This is considered authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the medical group/IPA or hospital must contact the Health Net Hospital Notification Unit within 24 hours or the next business day of the admission
- Document all calls.

Conditions of PCP Practice Closure

Found in: Operations Manuals > Provider Oversight Effective 06/01/2011

Participating primary care physicians (PCPs) may close their practices to new Health Net members while remaining open to members of other insured or managed health care plans, provided that the PCP meets Health Net of Arizona's threshold of 300 Health Net members before closing the panel.

If a patient of the PCP, while a member of another health care plan, joins Health Net, the PCP must continue to accept the member as a patient even if his or her practice is closed to new Health Net members.

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

Covering and Collaborating Physicians

Found in: Operations Manuals > Provider Oversight Effective 07/01/2013

Health Net providers who use other physicians to cover their practice while on vacation or leave must use their best efforts to find a Health Net participating physician within the same specialty. If a Health Net participating physician is unable to cover the practice, the following must occur:

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

Providers may request approval to use a non-participating, covering physician by contacting Health Net's Provider Network Management Department.

When choosing a provider to collaborate on a case, providers must use participating providers. Payment for surgical assistants as well as second opinions may be the responsibility of the requesting provider if the provider utilized is not participating with Health Net. Payment by Health Net for these services is dependant on medical appropriateness, contract status, member eligibility, and the member's benefit plan.

Deficit Reduction and Federal False Claims Act

Found in: Operations Manuals > Provider Oversight Effective 05/12/2016

The *Provider Participation Agreement* (*PPA*) requires all providers to adhere to Deficit Reduction Act (DRA) requirements. The DRA requires that any entity that receives or makes payments under a state plan approved under Title XIX or under any waiver of such plan, totaling at least $5 million annually, must establish written policies for its employees, management, contractors, and agents regarding the federal False Claims Act (FCA).

The FCA applies to claims presented for payment by federal health care programs. The FCA allows private persons to bring a civil action against those who knowingly submit false claims upon the government. The following are activities for which one may be liable under the FCA:

- Knowingly presenting to an officer or employee of the United States government a false or fraudulent claim for payment or approval.
- Knowingly making, using or causing a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting false or fraudulent claims allowed or paid.
- Having possession, custody or control of property or money used, or to be used by the government, and intending to defraud the government by willfully concealing property, delivering or causing to be delivered less property than the amount for which the individual receives.
- Authorizing to make or deliver a document, certifying receipt of property used by the government and intending to defraud the government and making or delivering a receipt without completely knowing that the information on the receipt is true.
- Knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property.
- Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

The definition of "knowing" and "knowingly" as it relates to the FCA includes actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, and/or acting in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required for reporting potential violations of the law.

Penalties under the Federal False Claims Act

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

Required Training and Education

Providers must train their staff on the FCA, including, but not limited, to the following topics:

- FCA provisions
- Administrative remedies for false claims and statements
- State laws related to civil or criminal penalties for false claims and statements
- Whistleblower protections under state laws

All training must be conducted in a manner that can be verified by Health Net Access.

Fraud, Waste and Abuse

Found in: Operations Manuals > Provider Oversight Effective 05/12/2016

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. Health Net Access investigates 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 noncompliant activities: Falsifying or tampering with company documents or records, accepting gifts or favors that may influence a business decision, violating Health Net Access' Code of Business Conduct and Ethics, or accessing personal information or protected health information (PHI) without authorization.

FWA Authority and Responsibility

The Health Net Special Investigations Unit has overall responsibility and authority for carrying out the provisions of the compliance program. Health Net Access is committed to identifying and reporting cases of suspected fraud and abuse. Health Net Access is required to report cases of suspected fraud or abuse to the Arizona Health Care Cost Containment System (AHCCCS) Office of Inspector General (OIG). Other agencies may have involvement in cases of criminal activity or abuse. The AHCCCS OIG is responsible for determining whether suspected fraud or abuse cases warrant referral to the State Attorney General's office. The AHCCCS Office of Inspector General has the authority to levy civil monetary penalties, issue recoupment letters and utilize other types of sanctions if fraud, waste or abuse is substantiated.

Reporting FWA

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 identification (ID) cards.

Health Net Access has adopted processes to receive, record and respond to compliance questions, reports of potential or actual noncompliance, and fraud, waste and abuse from contractors, agents, directors, enrollees, first-tier, downstream and related entities (FDRs), and providers. Health Net Access maintains confidentiality to the extent possible, allowing callers to remain anonymous if desired and ensuring nonretaliation against those who report suspected misconduct.

Anyone who suspects member or provider fraud or abuse may report it to the Health Net Special Investigations Unit. Providers must report suspected fraud involving a Health Net Access member to the Health Net Fraud Hotline. Health Net Access also asks providers to assist Health Net Access and, if necessary, the Arizona Department of Insurance (ADOI) or Arizona Health Care Cost Containment System (AHCCCS) in investigating instances of suspected fraud.

FWA State References

To prevent and detect fraud, waste and abuse, many states have enacted laws similar to the FCA but with state-specific requirements, including administrative remedies and relater rights. Those laws generally prohibit the same types of false or fraudulent claims for payments for health care related goods or services as are addressed by the federal FCA. Additional information on the Deficit Reduction Act and FCA is available on the following websites:

- www.azleg.state.az.us/ArizonaRevisedStatutes.asp (ARS 13-1802 Theft; 13-2002 Forgery; 13-2310 Fraudulent schemes and practices/willful concealment; 36-2918 Duty to report fraud).
- www.azsos.gov/rules/arizona-administrative-code (AAC R9- 22-1101 Civil Monetary Penalties and Assessments).

Health Net Policies and Procedures

Found in: Operations Manuals > Provider Oversight Effective 06/01/2009

All participating providers agree to abide by Health Net's policies and procedures. Failure to comply with Health Net's policies and procedures may result in claim delays, denials or sanctions, up to and including termination of the *Provider Participation Agreement* (*PPA*).

Questions regarding Health Net's policies and procedures and complete policies and procedures are available through Health Net's Provider Network Management Department.

Missed Appointments/No Show

Found in: Operations Manuals > Provider Oversight Effective 07/01/2013

Providers are expected to follow up with members who miss or cancel appointments and to notify Health Net when a member has missed or cancelled three or more visits. Providers may utilize the Health Net Access Missed Appointment/No Show Log.

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

Monitoring Medicaid Provider Exclusions

Found in: Operations Manuals > Provider Oversight Effective 02/17/2014

Arizona's Health Care Cost Containment System (AHCCCS) requires contractors and their subcontractors to monitor federal exclusions lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicaid enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to Medicaid enrollees. Health Net requires that its medical groups, hospitals, ancillary providers, and physicians frequently monitor federal exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from Medicaid participation are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM) website at www.sam.gov. In addition, Medicaid providers who are excluded by AHCCCS are listed on the AHCCCS website at www.azahcccs.gov/OIG/ExludedProviders.aspx.

Medicaid managed care programs and their subcontractors must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901. These federal exclusion requirements are further interpreted and communicated as guidance in the AHCCCS contract with Health Net. Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors, are available in 42 CFR §422.504(i)(4)(B)(v).

Health Net and Provider Responsibilities

Health Net is required to monitor federal exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net's Medicaid plans. Medicaid managed care entities and their subcontractors must check the LEIE and EEDP federal exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, or subcontractor for Medicaid-related activities. Medicaid managed care entities and their subcontractors must frequently monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority are available on the Exclusion Authority website at https://oig.hhs.gov/exclusions/authorities.asp.

The current LEIE is available on the OIG-HHS website at https://oig.hhs.gov/exclusions/exclusions_list.asp. Frequently asked questions (FAQs) and additional information on the LEIE is available at https://oig.hhs.gov/faqs/exclusions-faq.asp.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the EPLS. Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website at www.sam.gov, with additional information located under *Help > User Guides > Quick User Guides > Helpful Hints for Public Users.*

AHCCCS - OIG

AHCCCS - OIG provides a list of excluded Medicaid providers on the AHCCCS website at www.azahcccs.gov/OIG/ExludedProviders.aspx.

Health Net, its medical groups, hospitals, and ancillary providers cannot pay participating and non-participating parties or entities included on these lists for any services using federal funds, except for emergency services provided by excluded providers under certain circumstances. Contracting providers must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded

parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Health Net or CMS.

Office Hours and Equipment

Found in: Operations Manuals > Provider Oversight Effective 08/25/2011

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

PCP Responsibilities

Found in: Operations Manuals > Provider Oversight Effective 05/12/2016

Primary care providers (PCPs) are responsible for the following:

- Supervising, coordinating and providing care to each assigned member (except for children's dental, emergency, OB/GYN, family planning, and behavioral health services when provided without a PCP referral).
- Initiating referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health.
- Utilizing the Arizona Health Care Cost Containment Systems (AHCCCS)-approved Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking form.
- Providing clinical information regarding members' health and medications to the treating provider (including behavioral health providers) within 10 business days of a request for information from the provider.
- If serving children, enrolling as a Vaccines for Children (VFC) provider.

Provider Responsibilities

Found in: Operations Manuals > Provider Oversight Effective 05/12/2016

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 (non-discrimination).
- 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 when referring to non-participating providers.
- Providing Health Net Access with medical record information if requested for a member for processing his or her application for coverage; 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 employee 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 statute.
- 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.

The following responsibilities are minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of Health Net Access, provider contract and requirements in this manual. Health Net Access may or may not specifically communicate such terms in forms other than the contract and this manual. This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual.

Participating providers must ensure the following described below in detail:

- Adhere to the Arizona Health Care Cost Containment Systems (AHCCCS) appointment standards; refer to Appointment Standards section for more information.
- Provide service coverage on a 24/7 basis (including on-call).
- Respect AHCCCS member rights.
- Provide services in a culturally sensitive manager.
- Adhere to Americans with Disability Act (ADA) requirements.
- Provide services in a non-discriminatory manner.
- Report suspected fraud, waste and abuse.
- PCPs must utilize the AHCCCS-approved and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking form.
- PCPs must provide clinical information regarding a member's health and medication to a treating physician (including behavioral health) within 10 business days of the request.
- If treating children, enroll as a Vaccines for Children (VFC) provider.
- Provider complaint and appeal procedures.

Participating providers must complete initial, annual and ongoing Health Net Access trainings that include, but are not limited to, the following topics:

- Member appeals and grievances.
- Appointment standards and wait times.
- Language line services.
- Proper emergency department usage.
- Fraud, waste and abuse/ false claims act training.
- Contacting the health plan.
- How to file claims and claim disputes.

Other provider rights and responsibilities are included in the *Provider Participation Agreement (PPA).*

Regulatory Agency Information

Found in: Operations Manuals > Provider Oversight Effective 07/01/2013

Health Net is required to comply with all state and federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS), Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Insurance (ADOI).

After-Hours Sample Script - Chinese

非營業時間腳本範例

醫師和醫療團體可以使用下列腳本之一做為範本，確保即使在非營業時間或診所休診時間 Health Net 會員仍可及時取得醫療照護。

重要：在非營業時間提供有效率的電話服務可確保會員來電時能在 30 秒內接通電話服務人員或答錄機服務。

I. 電話服務人員接聽電話 (例如代客接聽電話服務或集中檢傷分類服務)：

如果來電會員認為自己發生醫療緊急情況，請告訴來電會員先掛斷電話，然後馬上撥 911 或前往最近的急診室 / 醫療機構。

如果來電會員認為情況緊急，或表示需要和醫師通話，請採取以下一項或多項動作，協助聯絡醫師：

- 暫時保留來電會員的電話，然後把來電會員轉接給待命醫師
- 留下來電會員的電話號碼，並告訴來電會員，醫師會在四小時內回電 (立即傳送訊息給醫師)
- 把待命醫師的傳呼號碼給來電會員，並告訴來電會員，醫師會在四小時內回會員電話；或指示來電會員前往最近的緊急照護中心
- 如果來電會員表示需要口譯服務，請使用口譯服務以協助聯絡

範例：

您好，這裡是<姓氏>醫師的<代客接聽電話服務 / 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請別掛斷，我會幫您轉接電話。

您好，這裡是<姓氏>醫師的<代客接聽電話服務 / 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，<姓氏>醫師可以協助您。請<傳呼 / 撥打> <電話號碼> 聯絡醫師。您應該會在四小時內接到回電。

II.答錄機接聽電話：

您好，這裡是 <輸入醫師姓名 / 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話 (選擇適當的選項)：

- *請稍候，我們會為您轉接<姓氏>醫師。*
- *您可以撥 <電話號碼> 直接聯絡待命醫師。*
- *請按 <號碼>，就可以轉接我們的緊急照護中心。我們緊急照護中心的地址是 <緊急照護中心地址> (應針對該地點提供適當的語言選項。)*
- *請按 <號碼>，就可以傳呼待命醫師。您應該會在四小時內接到回電。*

範例：

您好，這裡是 <醫師 / 醫療團體名稱> 的<姓氏>醫師。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請留下您的姓名、電話號碼，以及來電的原因，您應該會在四小時內接到回電。

您好，這裡是 <醫師姓名 / 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，您可以撥 <電話號碼> 或按 <號碼> 進行傳呼，就可以直接聯絡待命醫師。您應該會在四小時內接到回電。

After-Hours Sample Script - English

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within four hours (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within four hours, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>. You may expect a call back within four hours.

II. CALLS ANSWERED BY AN ANSWERING MACHINE:

Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within four hours*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within four hours.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within four hours.

After-Hours Sample Script - Spanish

Found in: Operations Manuals > Provider Oversight Effective 08/21/2012

EJEMPLO DE TEXTO PARA USAR FUERA DEL HORARIO DE ATENCIÓN

Los médicos y grupos médicos pueden utilizar uno de los siguientes textos como plantilla para garantizar que los afiliados a Health Net tengan acceso a una atenci n médica oportuna fuera del horario de atenci n o cuando sus consultorios están cerrados.

IMPORTANTE: Un servicio telef nico eficaz fuera del horario de atenci n garantiza que las personas que llaman puedan comunicarse con una voz en vivo o un contestador automático dentro de los 30 segundos.

I. LLAMADAS RESPONDIDAS POR UNA VOZ EN VIVO (como un servicio de mensajes telefónicos o un servicio centralizado de clasificación según las prioridades de atención):

Si la persona que llama cree que está teniendo una emergencia médica, indíquele que cuelgue y que llame al 911 de inmediato, o bien, que se dirija a la sala de emergencias/al centro médico más cercano.

Si la persona que llama cree que la situaci n es de urgencia o indica que necesita hablar con un médico, p ngala en contacto con el médico siguiendo uno o más de los pasos a continuaci n:

- Déjela en espera por un momento y luego comuníquela con el médico de guardia
- Solicítele el n mero de teléfono e indíquele que un médico le devolverá la llamada dentro de las cuatro horas (envíe un mensaje al médico de inmediato)
- Proporci nele el n mero del buscapersonas del médico de guardia e indíquele que el médico llamará al afiliado dentro de las cuatro horas, o bien, diríjala al centro de atenci n de urgencia más cercano
- Si una persona que llama indica que necesita servicios de intérprete, p ngala en contacto con quien pueda brindarle dichos servicios

Ejemplos:

Hola, usted se ha comunicado con el <servicio de mensajes telef nicos/servicio centralizado de clasificaci n seg n las prioridades de atenci n> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, permanezca en línea mientras le comunico.

Hola, usted se ha comunicado con el <servicio de mensajes telef nicos/servicio centralizado de clasificaci n seg n las prioridades de atenci n> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, el Dr./la Dra. <Apellido> puede ayudarle. Por favor, <llámelo/a> al <n mero de teléfono>. Calcule que se le devolverá la llamada dentro de las cuatro horas.

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMÁTICO:

Hola, usted se ha comunicado con <insertar el nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia (seleccione la opci n correspondiente):

- *Por favor, espere un momento mientras le comunico con el Dr./la Dra. <Apellido>*
- *Usted puede comunicarse directamente con el médico de guardia llamando al <n mero de teléfono>*
- *Oprima <n mero> para transferir la llamada a nuestro centro de atenci n de urgencia, que está ubicado en <direcci n del centro de atenci n de urgencia> (Se deben proporcionar las opciones de idioma correspondientes a la ubicaci n.)*
- *Oprima <n mero> para llamar al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de las cuatro horas.*

Ejemplos:

Hola, usted se ha comunicado con <Nombre del Médico/Group Médico> para el Dr./la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, deje un mensaje con su nombre, su n mero de teléfono y el motivo por el que llama, y calcule que se le devolverá la llamada dentro de las cuatro horas.

Hola, usted se ha comunicado con <Nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, puede comunicarse directamente con éste llamando al <n mero de teléfono> u oprimiendo <n mero> para acceder al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de las cuatro horas.

Quality Improvement

Found in: Operations Manuals Effective 01/01/2003

Quality Management Program

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

The Health Net Access quality management (QM) program is designed to monitor and evaluate the adequacy, safety and appropriateness of health care and administrative services provided to Health Net Access members on a continuous basis, and to support the identification and pursuit of opportunities aimed at improving health outcomes, as well as member and provider satisfaction. The QM program maintains full compliance with the QM requirements of regulatory agencies, such as the Arizona Healthcare Cost Containment System (AHCCCS) and the Centers for Medicare and Medicaid Services (CMS).

The QM program is conducted using a comprehensive, systematic and continuous multidisciplinary approach, integrating efforts and input from affiliated providers, members, Health Services Advisory Group (HSAG), Arizona Quality Improvement Organization, public health agencies, and community entities.

The program includes standards for clinical care and service, the measurement of compliance to the standards, and implementation of actions to improve performance. The scope of these activities takes into account the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. The QM program impacts the following:

- Health Net Access members in all demographic groups and in all Health Net Access contracting and licensed service areas.

- Network providers, including practitioners, facilities, hospitals, ancillary providers, and any other contracting or subcontracting provider types.
- Aspects of care, including level of care, health promotion, maternal and child health, continuity of care and transitions, appropriateness, timeliness, safety, and clinical effectiveness of care, and Health Net Access covered services.
- Communication ensuring the provision of culturally and linguistically appropriate care.
- Integration of behavioral health aspects of care to monitor and evaluate the care and service provided to improve behavioral health care, in coordination with other medical conditions and services.
- Provider performance related to professional licensing and credentialing, accessibility and availability of care, and quality and safety of care/service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
- All covered Health Net Access health care services.
- Internal administrative processes related to service and quality of care, provider qualifications and selection, confidential handling of medical records and information, preventive services, health education, information services, and quality management.

The program is reviewed, evaluated and updated at least annually or more often as necessary. On request, the Health Net Access Quality Management Department makes available to providers and members information about the QM program, including a description of the QM program and a report on Health Net Access' progress in meeting its goals and minimum performance standards.

Clinical Practice Guidelines

Found in: Operations Manuals > Quality Improvement Effective 01/01/2003

Overview

Found in: Operations Manuals > Quality Improvement > Clinical Practice Guidelines
Effective 05/18/2016

Health Net Access has clinical practice guidelines available to assist in the care of members. Guidelines are developed utilizing recommendations from national organizations, including, but not limited to, the American Diabetes Association (ADA), the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), American College of Cardiology (ACC), American Academy of Pediatrics (AAP), and the Centers for Medicare and Medicaid Services (CMS), as well as analysis of peer-reviewed literature. Many of the metrics in the guidelines are measured and reported to regulatory agencies, such as CMS or the Arizona Healthcare Cost Containment System (AHCCCS). Guidelines are posted on www.healthnet.com/ahcccsprovider and are accessible through Medical Policies link, which provides more condensed guidelines for the management of such conditions as asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, and heart failure (HF).

To receive a hard copy of the clinical practice guidelines, contact the Health Net Access Provider Network Management Department.

Compliance Monitoring

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

The Health Net Access Quality Management (QM) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities takes into account the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. The Health Net Access QM program develops an annual work plan addressing all Arizona Health Care Cost Containment System (AHCCCS) requirements and supports the Health Net Access QM goals and objectives, including compliance with all AHCCCS requirements.

Health Net Access established the Quality Management/Performance Improvement (QM-PI) Committee structure to foster quality management discussions and activities from multidisciplinary areas to ensure compliance with regulatory requirements. The Health Net QM-PI Committee structure promotes plan integration and provider network accountability for the identification, evaluation and measurement of key clinical and service activities.

Cultural and Linguistic Community Referral Resources

Health Net Access™

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
Alzheimer's Association	All	Provides information and services to empower and support individuals, families, caregivers, and communities affected by dementia and Alzheimer's.	Spanish, French, Chinese, Korean, Japanese, Vietnamese	www.alz.org/dsw/in_my_community_about.asp	(602) 528-0545
American Red Cross Grand Canyon Chapter	All	Provides relief to victims of disaster and helps prevent, prepare for and respond to emergencies.	Spanish	www.arizonaredcross.org	(602) 336-6660
Andre House	All	Provides transitional services from homelessness into stable employment and stable housing. They also provide a clothes closet, boot vouchers, laundry, showers, sleeping bags, blankets, and lockers. Office hours are Monday through Thursday, 10:00 a.m. to 12:00 p.m. and 1:00 p.m. to 3:00 p.m.; Saturday and Sunday, 1:00 p.m. to 3:00 p.m.	Spanish	www.andrehouse.org	(602) 255-0580
Area Agency on Aging	All	Offers information and services to seniors and their caregivers.	All	http://aaaphx.org/	(602) 264-2255
Arizona 2-1-1 Program	All	Provides information and referrals to various community resources, 24 hours a day, seven days a week. Resources include housing, food, legal support, school clothes, and other social support services.	All	http://211Arizona.org	211

(continued)

*In addition to English.

15-473b
FLY003632EH00 (9/15)

Health Net Access®

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
Arizona Department of Housing	All	Arizona's state housing agency provides information on apartment rentals, emergency repair and housing rehabilitation, eviction or foreclosure assistance, fair housing laws, homeownership assistance, and section 8 housing. Also offers unemployment, underemployment and reinstatement mortgage payment assistance, short sale assistance, and principal reduction assistance to qualified Arizona homeowners.	Spanish	www.azhousing.gov	(602) 771-1000
Arizona Early Intervention Program (AzEIP)	0–3	Arizona's statewide interagency system of supports and services for infants and toddlers with developmental delays or disabilities and their families.	All	www.azdes.gov/azeip/	(602) 532-9960
Arizona Health Care Cost Containment System (AHCCCS)	All	Offers Medicaid-related information to Arizona residents.	All	www.azahcccs.gov	(602) 417-4000
Arizona Smokers Helpline	All	Service and information for Arizonans who wish to quit tobacco.	All	http://ashline.org	1-800-556-6222
Arizona's Children Association	All	Provides foster care and adoption assistance; behavioral health and trauma/crisis response; family preservation and reunification; kinship services; parenting education; and transitional living services. All programs are family-focused, strength-based, culturally sensitive and outcome-driven.	Spanish	www.arizonaschildren.org	1-800-944-7611

(continued)

*In addition to English.

Health Net Access®

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
AZLinks	All	Arizona's Aging and Disability Resource Consortium (ADRC) helps Arizona seniors, people with disabilities, caregivers, and family members locate resources and services.	Spanish	www.azdes.gov/AZLinks.aspx	N/A
Behavioral Health Services	All	Offers a brief overview of public behavioral health services in Arizona with links to each of the Regional Behavioral Health Authorities (RBHA) in Arizona for women, men, children, teens, seniors, veterans, clinicians, and school representatives.	Spanish	www.azdhs.gov/index.php	(602) 364-4558
Birth to Five Hotline	0–5	Staffed by early childhood development specialists, registered nurses, disabilities specialists, early literacy specialists, and mental health counselors, the hotline provides a toll-free number for all Arizona families with young children and parents-to-be to call with questions or concerns about their infants, toddlers and preschoolers.	Spanish	www.azftf.gov/WhatWeDo/Programs/Pages/BirthtoFiveHelpline.aspx	1-877-705-5437
Bureau of Tobacco and Chronic Disease	All	Provides information on tobacco use, diabetes, heart health, and other chronic diseases.	Spanish	www.azdhs.gov/phs/chronicdisease	(602) 364-0824
Central Arizona Shelter Services	All	Provides shelter and support services to homeless adults and families. Services include showers, food, clothing, hygiene items, and case management. They also have a medical and dental facility, and offer employment services.	Spanish	www.cassaz.org	(602) 256-6945

(continued)

*In addition to English.

Health Net Access®

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
Chandler Christian Community Center	All	Meets basic needs, including providing emergency food boxes for people in crisis in the Chandler community, and works to empower individuals and families by providing programs that develop skills needed for self-sufficiency and long-term change.	Spanish	www.chandlerfoodbank.org	(480) 963-1423
City of Phoenix	All	Offers low-rent public housing, scattered sites home ownership, the affordable housing program, and senior and disabled housing programs for income-eligible individuals and families. Applications are required, and most programs have a wait list. Additional voucher programs offered are Native American Connections, Veterans Affairs, Child Support Services, Care Directions, Watkins Shelter, and Magellan.	Spanish	www.phoenix.gov/housing	(602) 262-4422
Community Kitchen	18+	All-expense-paid 16-week food service job development program (offered through St. Mary's Food Bank Alliance) that provides training and job placement in the food services industry. It is a second-chance program that works with low-income adults who are facing barriers to employment. Upon graduation, 94% of students are employed within the first month.	Spanish	www.firstfoodbank.org/community-kitchen	(602) 343-5622

(continued)

*In addition to English.

Health Net Access®

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
Department of Economic Security	All	Provides information on assistance services and programs available to Arizona families.	All	www.azdes.gov	(602) 542-5065
Find Help Phoenix	All	Simple website for community members to find information and referrals for community services.	Spanish	www.maricopa.gov/findhelpphx/categories.aspx	N/A
Head Start	All	National school readiness program for low-income children and their families. Also includes a wide range of education, health, nutrition, and social services to enrolled families.	Spanish	www.hsd.maricopa.gov/headstart	(602) 506-5911
Health Care for the Homeless	All	Free health care for homeless individuals on a walk-in basis. Proof of citizenship not required. Offers referrals to Circle The City for assistance with specialty health care, vision services, specialized mental health counseling, housing assistance, and general assistance for the homeless, as needed.	Spanish	www.maricopa.gov/publichealth/services/homeless/	(602) 372-2100
Health-e-Arizona PLUS	All	Website connecting individuals and families to health care coverage, benefits and services. Also useful for applying for or renewing AHCCCS benefits.	All	www.healthearizonaplus.gov/Default/Default.aspx	1-855-432-7587

(continued)

*In addition to English.

Health Net Access®

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
Phoenix Rescue Mission	All	Provides homeless emergency services by serving meals 365 days a year to men, women and children in the community. In addition to meals, provides showers, clean clothing, toiletries, and other needed items. Its three-acre campus offers a comprehensive approach to breaking the cycle of addiction, abuse, trauma, and homelessness. The Hope Coach van travels the streets of Phoenix, offering water, food, hygiene kits, socks, and other items to homeless men, women and families without shelter.	Spanish	http://phoenixrescuemission.org	(602) 233-3000
Salvation Army – Southwest	All	Offers healing; rescue from homelessness for families; safe haven from domestic abuse; freedom from alcohol, treatment for drug and gambling addictions; nourishment to the hungry and those in need; shelter and support to the homeless, shelter for seniors, developmentally disabled adults, and struggling families.	Spanish	http://salvationarmysouthwest.org	(602) 267-4122
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Women and children under age 5	Provides nutrition education and breastfeeding support services, supplemental nutritious foods and referrals to health and social services. WIC serves pregnant, breastfeeding, and postpartum women, infants, and children under age five determined to be at nutritional risk.	Spanish	www.maricopa.gov/publichealth/programs/wic/	(602) 506-9333

(continued)

*In addition to English.

Health Net Access

Cultural and Linguistic Community Referral Resources

Organization	Populations Served	Services	Languages Spoken*	Website	Phone Number
U.S. Department of Housing and Urban Development	All	Offers information and referral assistance on home buying, avoiding foreclosure, rental assistance, fair housing laws, subsidized housing options, and assistance locating affordable local housing.	All	http://portal.hud.gov/hudportal/HUD?src=/states/arizona/offices	(602) 379-7100

*In addition to English.

Page 7 of 7

Cultural and Linguistic Services

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

Cultural and linguistic services are available in written and verbal form for all identified threshold languages. Health Net Access provides 24-hour access to interpreter services. Cultural and linguistic services representatives develop, establish and monitor programs for members that meet the contractual requirements established by the Arizona Health Care Cost Containment System (AHCCCS).

For more information about cultural and linguistic services provided by Health Net Access, contact the Health Net Cultural and Linguistic Services Department.

For more information on how to work with an interpreter, providers should refer to the *Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations*.

To obtain a comprehensive list of community referrals, refer to the Cultural and Linguistics Community Referrals contact sheet.

Disease Management

Found in: Operations Manuals > Quality Improvement Effective 01/01/2003

Overview

Found in: Operations Manuals > Quality Improvement > Disease Management
Effective 06/01/2011

Health Net is committed to producing better outcomes for members through the promotion of evidence-based disease management programs. Health Net coordinates disease management programs for select disease states. This includes member education, regular contact with a case manager and coordination with the

member's physician to ensure the member receives the appropriate information and level of service. These programs are available to all Health Net members at no cost.

Arizona Smokers'' Helpline (ASHLine) Tobacco Cessation Program

Found in: Operations Manuals > Quality Improvement > Disease Management

Effective 03/20/2015

Health Net Access's Arizona Smokers' Helpline (ASHLine) program offers a variety of options to members to help them quit smoking and stay tobacco-free. Health Net Access members may access free telephone counseling from ASHLine in English and Spanish. ASHLine's telephone support includes:

- Treatment sessions scheduled at the participant's convenience
- Access to tobacco treatment specialists for the duration of treatment
- Recommendations on type, dose and duration of medication, if appropriate
- Educational materials

In addition to free telephone-based coaching services, members may also use an online tobacco cessation program through WebQuit. Members can work through activities, set goals and monitor their progress 24 hours a day, 7 days a week. WebQuit is available at www.ashline.org.

Decision Power Disclaimer

Found in: Operations Manuals > Quality Improvement > Disease Management

Effective 12/07/2015

Health Net members have access to Decision Power® through their current enrollment with any of the following Health Net companies: Health Net of Arizona, Inc., Health Net Access, Inc. and Health Net Life Insurance Company. Decision Power is not part of Health Net's commercial medical benefit plans nor affiliated with Health Net's provider network and it may be revised or withdrawn without notice. Decision Power is part of Health Net's Medicare Advantage benefit plans. It is not affiliated with Health Net's provider network. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies. Health Net and Decision Power are registered service marks of Health Net, Inc. All rights reserved.

Decision Power Program

Found in: Operations Manuals > Quality Improvement > Disease Management

Effective 05/18/2016

The Decision Power® program provides a fully integrated, health management solution to improve the health and quality of life for Health Net Access members. Through personalized interventions and contemporary behavior change methodologies, an experienced clinical staff can assist members at-risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. Decision Power includes disease management, case management and complex case management programs.

The Decision Power program provides support 24 hours a day, seven days a week, through Nurse24 services. Health Net Access members can refer to the back of their member identification (ID) cards for this telephone number. Decision Power clinicians are specially trained professionals, who are always available to support Health Net Access members through telephone interaction. The goal of the Decision Power program is to support members' self-care skills, increase their self-confidence and help them work effectively with their physicians to manage their health conditions. Providers may also refer Health Net members to the Decision Power program by fax, or they can call Decision Power to discuss referrals.

Disease Management Program

The Health Net Access disease management program provides support to members with chronic conditions, including heart failure (HF), chronic obstructive pulmonary disease (COPD), coronary heart disease (CAD), diabetes, and asthma. Decision Power disease management helps increase the efficiency and effectiveness of care, leads to more timely actions by the member, and helps develop more personalized and actionable solutions that ultimately lead to improved health outcomes. Health Net Access provides participants and their providers the programs, tools, connectivity, and information to make better health care decisions to:

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

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

Case Management

The Health Net Access complex case management program targets members with the most complex cases, often with life-limiting diagnoses, and assists members who have critical barriers to their care. A trained nurse case manager provides intensive, face-to-face contact with Health Net Access members, their families and caregivers. These members often have multiple comorbid conditions and need assistance in planning, managing and executing their care.

This ambulatory case management program is available to high-risk members with less complex needs. The initial assessment is conducted over the telephone with a minimum follow-up contact every other week until the members' needs are met and the case can be closed. Use the Health Net Case Management Referral Form for Health Net Access members to refer members for case management.

Neonatal Intensive Care Management

Neonatal intensive care management is available for Health Net Access members who are admitted to neonatal intensive care units (NICUs) or specialty care nurseries. A trained neonatal nurse case manager monitors the progress of the infant from initial admission into NICU through the transition to home. This trained clinician ensures that parents and family members are prepared to take their newborn home, and assists with arranging necessary home-based services for the family.

Health Education Materials

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

Printed information for Health Net Access members, including health education brochures and fact sheets, is provided at a sixth-grade (or lower) reading level in an easy-to-read format. Diverse cultural backgrounds are taken into consideration when these materials are created and translated. The Health Net Cultural and Linguistic Services Department reviews these materials for accuracy of translation, cultural content and reading level.

Providers are required to have educational materials available in approved threshold languages. Health Net Access evaluates member materials with the assistance of experts, focus groups, and individual and group interviews when appropriate.

Health health education materials may be ordered by mailing or faxing a completed copy of the *Provider Order Form for Health Education Materials* to the Health Net Health Education Department .

Health Net Quality Management-Performance Improvement Committee

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

The Health Net Access Quality Management-Performance Improvement (QM-PI) Committee structure includes various sub-committees and workgroups. The Health Net Access QM-PI Committee has been delegated the responsibility for oversight of the Health Net Access Quality Management (QM) program from the board of directors and is responsible for monitoring the quality and safety of care and services rendered to Health Net Access members. The Health Net Access QM-PI Committee ensures the QM program, work plan and annual evaluation are implemented effectively and result in improvements in care and service. The Health Net Access QM-PI also assesses and recommends, as needed, resources to implement quality improvement activities

The following committees report to the Health Net Access QM-PI Committee:

- Health Net AccessMedical Management/Utilization Management (MM/UM) Committee
- Health Net Access Credentialing/Peer Review Committee
- Pharmacy and Therapeutics Committee
- Delegation Oversight Committee
- Health Net Access Network QM Subcommittee

Health Net Access Medical Management/ Utilization Management Committee

The MM/UM Committee is responsible for the review of the medical management and utilization management data and management activities and utilizes the data to make recommendation for action. The committee monitors the effectiveness of any action taken and reports significant findings to the Health Net Access QM-PI Committee. The MM/UM Committee monitors the activities and patterns in:

- Pharmacy management
- Prior authorization and referral management
- Development and/or adoption of practice guidelines
- Concurrent review
- Continuity and coordination of care
- Over- and under-utilization patterns
- New medical technologies and use of existing technologies
- Disease management and chronic care programs
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Maternal child health

The MM/UM Committee is chaired by the Health Net Access medical director.

Credentialing/Peer Review Committee

The Health Net Access Credentialing/Peer Review Committee verifies and reviews practitioners and organizational providers who contract to render professional services to Health Net Access members for training, licensure, competency, and qualifications that meet established standards for credentialing and recredentialing. The Credentialing Committee ensures credentialing and recredentialing criteria for participation in the Health Net Access network are met and maintained. The Health Net Access QM-PI Committee delegates authority and responsibility for credentialing and recredentialing and peer reviews to this committee. This committee is also responsible for peer review activities and decisions regarding quality management follow-up on service and clinical matters, including quality of care cases. The committee provides a forum for instituting corrective action as necessary, and assesses the effectiveness of these interventions through systematic follow-up for both inpatient and outpatient care and services.

This committee reports to the Health Net Access QM-PI Committee and provides a summary of activities to the Health Net Access board of directors.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee ensures appropriate and cost-effective delivery of pharmaceutical agents to Health Net Access membership. Committee responsibilities include the review and approval of policies that outline pharmaceutical restrictions, preferences, management procedures, explanation of limits or quotas, delineation of Preferred Drug List (PDL) exceptions, substitution and interchange, step-therapy protocols, and adoption of prescription safety procedures.

The P&T Committee includes a Health Net medical director, practitioners and clinical pharmacists and reports to the Health Net Access QM-PI Committee.

Delegation Oversight Committee

The Delegation Oversight Committee (DOC) is responsible for overseeing the formal process by which another entity is given the authority to perform functions on behalf of Health Net Access. The DOC ensures there is a contractual agreement between Health Net Access and the delegate, which outlines responsibilities, activities, reporting, evaluation process, and remedies for deficiencies. The DOC's responsibilities include:

- Monitoring and evaluating a delegate's performance through due diligence prior to granting delegation.
- Monitoring and evaluating a delegate's performance through routine reporting and an annual evaluation of the delegate's processes in compliance with all regulatory and accreditation standards.
- Taking action when monitoring reveals deficiencies in the delegate's processes.

Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Population

BETTER COMMUNICATION, BETTER CARE:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

Health Net®

Introduction for Healthcare Professionals:

Why was this tool kit created? How can it help my practice?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. Because of changes in demography, in our awareness of differences in individual belief and behavior, and new legal mandates, we are constantly presented with new challenges in our attempts to deliver health care to a diverse patient population. The material in this tool kit will provide you with resources to address the very specific operational needs that often arise in a busy practice because of the changing service requirements and legal mandates.

The tool kit contents are organized into four sections, each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents.

Interaction with a diverse patient base: encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.

Communication across language barriers: tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and language skill self-assessment tools.

Understanding patients from various cultural backgrounds: tips for talking with a wide range of people about sex, pain management across cultures, and information about different cultural backgrounds.

References and resources: some key legal requirements, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org

On behalf of the ICE Cultural and Linguistic Workgroup,

Margie Akin, Ph.D.
Molina Healthcare, Inc.
Research Anthropologist
University of California, Riverside

Diana Carr, MA
Health Net of California, Inc.
Medical Anthropologist

Peggy Payne, MA
SCAN Health Plan
Certified Gerontologist
Certified Diabetes Educator

Better Communication, Better Care: Provider Tools to Care for Diverse Populations

Section A

A Guide to Information in Section A

RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

We recognize that every patient encounter is unique. Every patient is different in age, sex, ethnicity, religion or sexual preference and will bring to the medical encounter their unique perspectives and experiences. This factor will always impact communicati on, compliance and health care outcomes.

The suggestions presented here are intended to help build sensitivity to differences and styles, minimize patient-provider and patient-office staff miscommunication, and foster an environment that is non-threatening and comfortable to the patient.

This information may assist you to:

- Improve health care delivery and outcomes
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase adherence
- Avoid Civil Rights Act violations
- Identify opportunities to improve office staff cultural and linguistic c ompetency

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A one-page tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A one-page tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	A two-page overview of the impact of non-verbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A two-page handout elaborating on the signs of low health literacy and how to address them.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style, however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening. Some patients can tell you more about their health through story telling than by answering direct questions.

A-02-04 (pg. 1 of 1)

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. **Build rapport with the patient.**
   - Address patients by their last name. If the patient's preference is n ot clear, ask, "How would you like to be addressed?"
   - Focus your attention on patients when addressing them.
   - Learn basic words in your patient's primary language, like "hello" or "thank you".
   - Recognize that patients from diverse backgrounds may have different comm unication needs.
   - Explain the different roles of people who work in the office.

2. **Make sure patients know what you do.**
   - Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
   - Have instructions available in the common language(s) spoken by your p atient base.

3. **Keep patients' expectations realistic.**
   - Inform patients of delays or extended waiting times. If the wait is long er than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. **Work to build patients' trust in you.**
   - Inform patients of office procedures such as when they can expect a call with lab results how follow-up appointments are scheduled, and routine wait times.

5. **Determine if the patient needs an interpreter for the visit.**
   - Document the patient's preferred language in the patient chart.
   - Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
   - Assess your bilingual staff for interpreter abilities. (see Employee La nguage Skills Self Assessment Tool).
   - Possible resources for interpreter services are available from health pl an the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. **Give patients the information they need.**
   - Have topic-specific health education materials in languages that reflect your patie nt base. (Contact your contracting health plans/contracted medical groups for resour ces.)
   - Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. **Make sure patients know what to do.**
   - Review any follow-up procedures with the patient before he or she leaves your office.
   - Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
   - Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your pati ent base. (Contact your contracting health plans/contracted medical groups for resources.)

A-03-04 (pg. 1 of 1)

NON-VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our non-verbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with soon became extremely frustrated because she felt she was not getting th questions and never met her eyes. She reasoned from this that he was un listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging and keep their first well woman appointment. The physician stated that gh no-show rate and appointments did not go as smoothly as the physician would like

Talk the patient through each exam so that the need for the physical contact is understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

NON-VERBAL COMMUNICATION AND PATIENT CARE (Continued)

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd motioning with his right index finger. Elena remained where she was and "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[2]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. confused by his appearance because she knew that he was receiving servic thought the front office either made a mistake documenting his ability t pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family - the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began a of his Vietnamese patient Tanya. She looked tense, staring at the ground information. No matter how clearly he asked the question he couldn't get Tanya to take the visit.

The use of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

[1,2] Galanti, G. (1997). *Caring for Patients from Different Cultures.* University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE"
A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of – acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations-** *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion-** *ask about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identify your patient's language needs including health literacy levels.* *Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment -** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

A-05-04 (pg. 1 of 1)

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

Low health literacy can prevent patients from understanding their health

Health Literacy is defined by the National Health Education Standards (*) as *"the capacity of an individual to obtain, interpret, and understand basic health information and servic information and services in ways which are health-enhancing."*

This includes the ability to understand written instructions on prescrip tion drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to r ead and is not necessarily related to years of education. A person who functions adequately at home or work may have margin al or inadequate literacy in a health care environment.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a r ange of factors including age, socioeconomic background, education and culture.
  Example: Some seniors may not have had the same educational opportunitie
- A patient's culture and life experience may have an effect on their h ealth literacy.
  Example: A patient's background culture may stress verbal, not written, communication styles.
- An accent, or a lack of an accent, can be misread as an indicator of a person's ability to read English.
  Example: A patient, who has learned to speak English with very little ac not be able to read instructions on a prescription bottle.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6–12 years to develop.

Possible Signs of Low Health Literacy

Your patients' may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behavior may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Tips for Dealing with Low Health Literacy

- Use simple words and avoid jargon.
- Never use acronyms.
- Avoid technical language (if possible).
- Repeat important information – a patient's logic may be different from yours.
- Ask patients to repeat back to you important information.
- Ask open-ended questions.
- Use medically trained interpreters familiar with cultural nuances.
- Give information in small chunks.
- Articulate words.
- "Read" written instructions out loud.
- Speak slowly (don't shout).
- Use body language to support what you are saying.
- Draw pictures, use posters, models or physical demonstrations.
- Use video and audio media as an alternative to written communications.

(*) Joint Committee on National Health Education Standards, 1995

A-06-04 (pg. 1 of 1)

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions are meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By int egrating some or all of these questions into your interview process, you will be more likely to hire s taff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between pat ients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

INTERVIEW QUESTIONS

Q. What experience do you have in working with people of diverse backgro ethnicities? The experiences can be in or out of a health care environment.

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.

You will want to get a sense that the interviewee has an appreciation fo r working with people from diverse backgrounds and understands the accompanying complexities and ne eds in an office setting.

Q. In the health care field we come across patients of different ages, l orientation, religions, cultures, genders, and immigration status, etc. skills from your past customer service or community/healthcare work do you think are relevant to this job?

This question should allow a better understanding of the interviewees ap proach to customer service across the spectrum of diversity, their previous experience, and if thei r skills are transferable to the position in question. Look for examples that demonstrate an understandin g of varying needs. Answers should demonstrate listening and clear communication skills.

Q. What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because the

The answer should demonstrate an understanding of the behaviors that fac ilitate respect and the type of prejudices and bias that can result in substandard service and care.

Section B

A Guide to Information in Section B

RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when acces sing health care services. These barriers have a negative impact on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assis t health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials are available in this section:

Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
10 Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Telephonic Interpreting Companies	Sample list of organizations that provide interpreter services.
Language Identification Flashcards	Tool to identify patient languages.
Common Signs in Multiple Languages (English-Spanish-Vietnamese–Chinese)	Simple signs that can be enlarged and posted in your facility.
Common Sentences in Multiple Languages (English-Spanish-Vietnamese–Chinese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Employee Language Skills Self-Assessment Tool	Self-assessment tool to capture the language capability of bilingual health care providers.

Tips for Working with Limited English Proficient (LEP) Members

- **California law** requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

- **Who is a LEP member?**
  Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

- **How to identify a LEP member over the phone**
  - Member is quiet or does not respond to questions
  - Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
  - Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
  - Member self identifies as LEP by requesting language assistance.

- **Tips for working with LEP members and how to offer interpreter services**
  1) Member speaks no English and you are unable to discern the language
  → Connect with contracted telephonic interpretation vendor to identify language needed.

  2) Member speaks some English:
  → Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.

  → How to offer interpreter services:
  "*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

  Or

  "*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

- **Best practice to capture language preference**
  For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.
  "*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:
http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

B-10-10 (pg.1 of 1)

TIPS FOR COMMUNICATING ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barr iers that undermine their ability to understand information given by healthcare providers as well as instr uctions on prescriptions and medication bottles, appointment slips, medical education brochures, doct or's directions, and consent forms. They experience more difficulty (than other patients) processi ng information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to poi nt to their language of preference.
- Post information relative to the availability of interpreter services.
- Make available and encourage patients to carry "I speak…." or " Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

- For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.
- Post color stickers on the patient's chart to flag when an interprete r is needed. (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for sho rt conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provide consistent patient interactions for a larg e number of patients.
- For reliable patient communication, avoid using minors and family member s.

Tips to Overcome Language Barriers

- Use simple words; avoid jargon and acronyms.
- Limit/avoid technical language.
- Speak slowly (don't shout).
- Articulate words completely.
- Repeat important information.
- Provide educational material in the languages your patients read.
- Use pictures, demonstrations, video or audiotapes to increase understanding.
- Give information in small chunks and verify comprehension before going on.
- Always confirm patient's understanding of the information - patient's logic may be different from yours.

B-02-04 (pg. 1 of 1)

Tips for Working with Interpreters

Telephonic Interpreters

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits." * Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way. *
- ABOVE ALL, BE PATIENT with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

- When the interpreter comes onto the line let the interpreter know the following: **
  - Who you are
  - Who else is in the room
  - What sort of office practice this is
  - What sort of appointment this is

  For example, "Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **
- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it. **

On-site Interpreters

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.

- For face-to-face interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained. For sign language (ASL) interpreting, it is best to position the interpreter beside the patient so the patient can capture the hand signals easily.
- Be aware of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- Be attentive to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- Greet the patient first, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **
- Speak in: Standard English (avoid slang) **
  - Layman's terms (avoid medical terminology and jargon)
  - Straightforward sentence structure
  - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use. This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

Footnotes:

** **"Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.**

* **"Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).**

TIPS FOR LOCATING INTERPRETER SERVICES

First, assess the oral linguistic needs of your Limited English Proficie nt (LEP) patients. Second, assess the services available to meet these needs.

Assess the language capability of your staff *(See Employee Language Skills Self-Assessment)*

- Keep a list of available bilingual staff who can assist with LEP patient s on-site.

Assess services available through patient health plans

- Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their memb ers.
- Identify the policies and procedures in place to access interpreter serv ices for each plan you work with.
- Keep an updated list of specific telephone numbers and health plan contacts for language services.
- Ask the agency providing the interpreter for their training standards an d methods of assessing interpreter quality.
- Don't forget to inquire about Telecommunication Device for the Deaf (TDD) services for the hard of hearing/deaf.

If services are covered, identify the appropriate contact and request the health plan's process to access services.

- Determine if face-to-face and/or telephone interpreters are covered.
- If face-to-face interpreters are covered, have the following information ready before requesting the interpreter: gender, age, language needed, date/time of a ppointment, type of visit, and office specialty.
  - *Remember to follow all HIPAA regulations when transmitting any patient-identifiable information to parties outside your office.*
- If telephone interpreters are covered, relay the pertinent patient infor will help the interpreter better serve the needs of the patient and the

If interpreter services are NOT covered by the patient's health plan, **find other resources** to meet the linguistic needs of your LEP patients.

- Use trained/capable internal staff.
- Contract with a telephonic interpreting company. (See *Telephonic Interpreting Companies.*) It is recommended that you assess the quality of the services provided by these vendors.
- Check for services available through Community Based Organizations. Some provide free face-to-face interpreter services for the community or they may offer low fees.
- Depending on the linguistic needs of your LEP population, you may have to consider hiring a professional interpreter.
- For further information, you may contact the National Council on Interpr etation in Health Care, the Society of American Interpreters, the Translators & Interprete rs Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

B-04-04 (pg. 1 of 1)

TELEPHONIC INTERPRETING COMPANIES

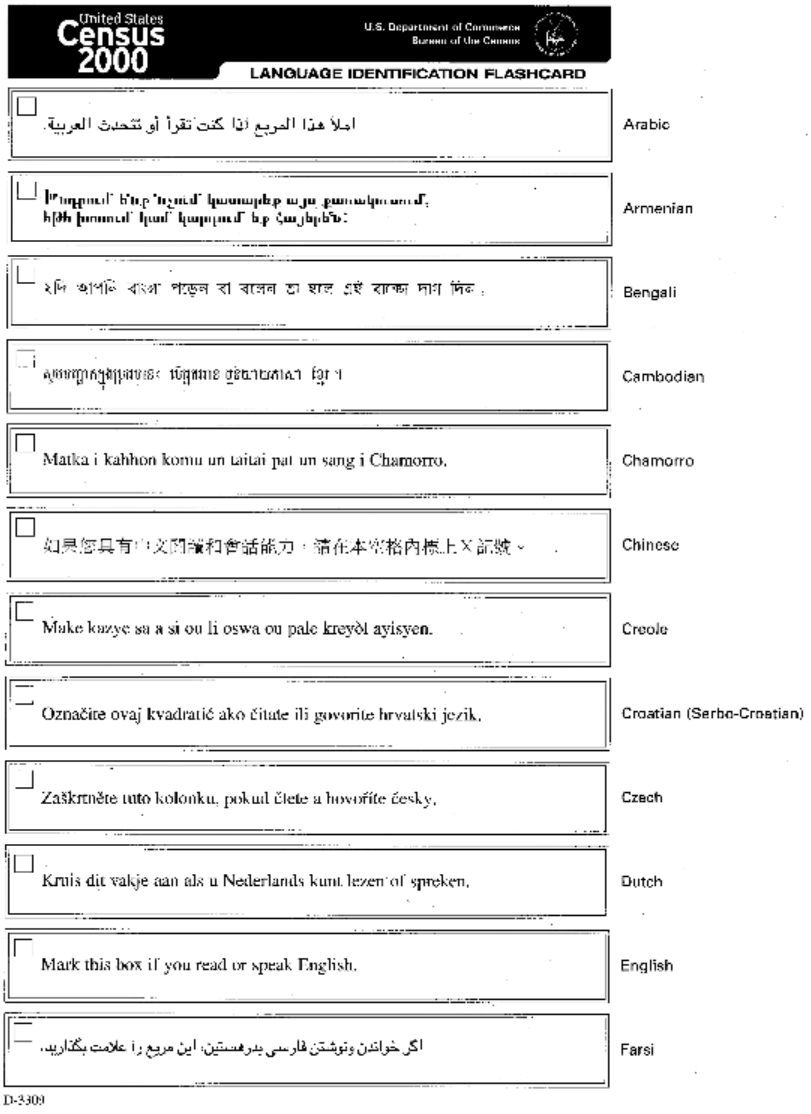
Price per Minute: Prices may range from $1.25 to $4.50 per minute. Some companies charge different rates depending on the language requested. Other companies charge the same rate regardless of language. Most rates are negotiable depending on volume.
Start-up Costs: There might be a $150 set-up charge and a $50 monthly service fee, but often these costs are waived.
Staff Training: On-site and teleconferencing training on how to use telephonic interpretation is available.
Connection Time: Connection times range from 30 to 60 seconds.
Other Services: **All** companies have training materials, custom reports and equipment available. Some have dual handset telephones available.

		Industry Specialization	Standards for Interpreters *Screening/Evaluation Process, Training of Interpreters*	Location
This list is intended to give you a sample of vendors that offer telephone interpretation services, and is not an endorsement or a recommendation. *You should conduct your own research to assess the quality of the services provided by these vendors.*	**CyraCom International** **800-713-4950**	Medical	Completion of the CyraCom Interpreter Qualification Process	5780 North Swan Road Tucson, AZ 85718 Phone 800-713-4950 / Fax 520-745-9022
	Interpreting Services International, Inc. (ISI) **818-753-9181**	Medical	Completion of the ISI Interpreter Training and Assessment Program (ITAP)	6180 Laurel Canyon Blvd., Suite 245 North Hollywood, CA 91606 Phone 818-753-9181 / Fax 818-753-9617
	Language Line Services (LLS) **877-886-3885**	All industries	Completion of the Language Line Medical Certification Program	1 Lower Ragsdale Drive, Bldg. 2 Monterey, CA 93940 Phone 877-886-3885
	Network Omni Services **800-543-4244**	All industries	Not specified	4353 Park Terrace Drive Westlake Village, CA 91361 Phone 800-543-4244 / Fax 818-735-6305
	Pacific Interpreters **800-311-1232**	Medical	• 2 yrs of college education • Formal training as interpreter • Professional certification • Active membership in a professional organization	707 SW Washington, Suite 200 Portland, OR 97205 Phone 800-311-1232 / Fax 503-445-5501
	Tele-Interpreters **800-811-7881**	Medical Legal Insurance	Primarily recruit from interpretation schools	500 North Brand Blvd., Suite 1700 Glendale, CA 91203 Phone 800-811-7881

Language Identification Flashcards

The sheets in this tool can be used to assist the office staff or physic ian in identifying the language that your patient is speaking. Pass the sheets to the patient and point to t he English statement. Motion to the patient to read the other languages and to point to the language tha t the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The Language Identification Flashcards were developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.



United States Census 2000

U.S. Department of Commerce
Bureau of the Census

LANGUAGE IDENTIFICATION FLASHCARD

☐ املأ هذا المربع إذا كنت تقرأ أو تتحدث العربية.	Arabic
☐ [illegible]	Armenian
☐ যদি আপনি বাংলা পড়েন বা বলেন তা হলে এই বাক্সে দাগ দিন।	Bengali
☐ [illegible]	Cambodian
☐ Matka i kahhon komu un taitai pat un sang i Chamorro.	Chamorro
☐ 如果您具有中文阅读和會話能力，請在本表格內標上X記號。	Chinese
☐ Make kazye sa a si ou li oswa ou pale kreyòl ayisyen.	Creole
☐ Označite ovaj kvadratić ako čitate ili govorite hrvatski jezik.	Croatian (Serbo-Croatian)
☐ Zaškrtněte tuto kolonku, pokud čtete a hovoříte česky.	Czech
☐ Kruis dit vakje aan als u Nederlands kunt lezen of spreken.	Dutch
☐ Mark this box if you read or speak English.	English
☐ اگر خواندن وتوشتن فارسی بدرهستین، این مربع را علامت بگذارید.	Farsi

D-2309

☐ Cocher ici si vous lisez ou parlez le français.	French
☐ Kreuzen Sie dieses Kästchen an, wenn Sie Deutsch lesen oder sprechen.	German
☐ Σημειώστε αυτό το πλαίσιο αν διαβάζετε ή μιλάτε Ελληνικά.	Greek
☐ अगर आप हिन्दी बोलते या पढ़ सकते हों तो इस गोले पर चिह्न लगाएँ।	Hindi
☐ Kos lub voj no yog koj paub twm thiab hais lus Hmoob.	Hmong
☐ Jelölje meg ezt a kockát, ha megérti vagy beszéli a magyar nyelvet.	Hungarian
☐ Markaam daytoy nga kahon no makabasa wenno makasaoka iti Ilocano.	Ilocano
☐ Marchi questa casella se legge o parla italiano.	Italian
☐ 日本語を読んだり、話せる場合はここに印を付けてください。	Japanese
☐ 한국어를 읽거나 말할 수 있으면 이 칸에 표시하십시오.	Korean
☐ ໃຫ້ໝັ້ນໃຈວ່າ ທ່ານອ່ານ ຫຼື ເວົ້າພາສາລາວ.	Laotian
☐ Zaznacz tę kratkejeżeli czyta Pan/Pani lub mówi po polsku.	Polish
☐ Assinale este quadrado se você lê ou fala Português.	Portuguese

D-3309

☐ Însemnaţi această căsuţă dacă citiţi sau vorbiţi Româneşte.	Romanian
☐ Пометьте этот квадратик, если вы читаете или говорите по-русски.	Russian
☐ Maka pe fa'ailoga le pusa lea pe afai e te faitau pe tusitusi i le gagana Samoa.	Samoan
☐ Обележите овај квадратић уколико читате или говорите српски језик.	Serbian (Serbo-Croatian)
☐ Označte tento štvorček, ak viete čítať alebo hovoriť po slovensky.	Slovak
☐ Marque esta casilla si lee o habla español.	Spanish
☐ Markahan ang kahon na ito kung ikaw ay nagsasalita o nagbabasa ng Tagalog.	Tagalog
☐ [illegible]	Thai
☐ Faka'ilonga'i 'ae puha ko'eni kapau 'oku te lau pe lea 'ae lea fakatonga.	Tongan
☐ Відмітьте цю клітинку, якщо ви читаєте або говорите українською мовою.	Ukrainian
☐ اگر آپ اردو پڑھتے یا بولتے ہیں تو س خانہ میں نشان لگائں.	Urdu
☐ Xin đánh dấu vào ô này nếu quý biết đọc và nói được Việt Ngữ.	Vietnamese
☐ צייכנט דעם קעסטל אויב איר שרייבט אדער ליינט אידיש.	Yiddish

D-3309

COMMON SIGNS IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		**Welcome**
Español	*Spanish*	**Bienvenido/a**
Tieng Viet	*Vietnamese*	**Han hanh tiep đon quy vị**
中文	*Chinese*	**歡迎**

English		**Registration**
Español	*Spanish*	**Oficina de Registro**
Tieng Viet	*Vietnamese*	**Quay tiep khach**
中文	*Chinese*	**登記處**

English		**Cashier**
Español	*Spanish*	**Cajera**
Tieng Viet	*Vietnamese*	**Quay tra tien**
中文	*Chinese*	**收銀部**

English		**Enter**
Español	*Spanish*	**Entrada**
Tieng Viet	*Vietnamese*	**Loi vao**
中文	*Chinese*	**入口**

English		**Exit**
Español	*Spanish*	**Salida**
Tieng Viet	*Vietnamese*	**Loi ra**
中文	*Chinese*	**出口**

English		**Restroom**
Español	*Spanish*	**Baños**
Tieáng Vieät	*Vietnamese*	**Phong ve sinh**
中文	*Chinese*	**洗手間**

B-07-04 (pg. 1 of 1)

COMMON SENTENCES IN MULTIPLE LANGUAGES
(ENGLISH-SPANISH-VIETNAMESE-CHINESE)

This tool is designed for office staff to assist in basic entry-level communication with Limited English Proficient (LEP) patients. Point to the sentence you wish to communicate and your LEP patient may read it in his/her language of preference. The patient can then point to the next message.

English	Spanish / Español	Vietnamese / Tiếng Việt	Chinese / 中文
Point to a sentence	**Señale una frase**	**Xin chỉ vao cau**	**指向句子**
Instructions	***Instrucciones***	***Chỉ Dan***	***指示***
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chung ta co the dung nhưng the nay đe giup chung ta hieu nhau. Xin chỉ vao cau đung nghĩa quy vị muon noi. Chung toi se nhơ mot thong dịch vien den giup neu chung ta can noi nhieu hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

English	Spanish / Español	Vietnamese / Tieng Viet	Chinese / 中文
Point to a sentence	Señale una frase	Xin chỉ vao cau	p指向句子

Courtesy statements	*Frases de cortesía*	*Tư ngư lịch sư*	***禮貌敘述***
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會

English	Spanish / Español	Vietnamese / Tieng Viet	Chinese / 中文
Point to a sentence	Señale una frase	Xin chỉ vao cau	p指向句子

Patient may say….	*El paciente puede decir…*	*Benh nhan co the noi...*	***病人可能會說..***
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是…
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位傳譯員…
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生是因為...
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

English	Spanish / Español	Vietnamese / Tieng Viet	Chinese / 中文
Point to a sentence	Señale una frase	Xin chỉ vao cau	p指向句子
Patient may say…	***El paciente puede decir…***	***Benh nhan co the noi...***	***病人可能會說...***
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？
Point to a sentence	Señale una frase	Xin chỉ vào câu	指向句子
Staff may ask or say…	***El personal del médico le puede decir…***	***Nhân viên có thể hỏi hoặc nói..***	***職員可能會問或說。。。***
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

English	Spanish / Español	Vietnamese / Tieng Viet	Chinese / 中文
Point to a sentence	Señale una frase	Xin chỉ vao cau	p指向句子
Staff may ask or say…	***El personal del médico le puede decir…***	***Nhân viên có thể hỏi hoặc nói..***	***職員可能會問或說。。。***
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼名字？
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人？
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病人的:
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號碼
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期:
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	月/日/年
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現在，請填寫這表格*

COMMON SENTENCES IN MULTIPLE LANGUAGES
(ENGLISH-SPANISH-FRENCH CREOLE)

This tool is designed for office staff to assist in basic entry-level communication with Limited English Proficient (LEP) patients. Point to the sentence you wish to communicate and your LEP patient may read it in his/her language of preference. The patient can then point to th next message.

English	Spanish / Español	Creole/ Kreyòl
Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**
Instructions	***Instrucciones***	***Esplikasyon***
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES
(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kreyòl
Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Koutwazi***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an kapab di*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè doktè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	Èske mwen ka gen yon entèprèt?

COMMON SENTENCES IN MULTIPLE LANGUAGES
(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kreyòl
Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**
Staff may ask or say….	***El personal del médico le puede decir…***	**Anplwaye medikal la kapab di oubyen mande..**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen kapab pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon entèprèt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon entèprèt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES
(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kreyòl
Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**
Staff may ask or say….	***El personal del médico le puede decir…***	**Anplwaye medikal la kapab di oubyen mande...**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **pou pasyan an**:
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou / Ane
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	***Kounye a, ekri enfimasyon yo mande nan papye sa yo.***

EMPLOYEE LANGUAGE SKILLS
SELF-ASSESSMENT TOOL

Dear Physician:

The attached self-assessment tool is provided as a resource to assist you in identifying language skills and resources existing in your health care setting. This voluntary tool will provide a basic and subjective idea of the bilingual capabilities of your staff. This screening tool is not meant to meet the CA Language Assistance Program law requirements.

You may distribute the tool to **all your clinical and non-clinical employees using their non-English language skills in the workplace**. The information collected may be used as a first step to improve communication with your diverse patient base.

You may wish to write an introductory note along the following lines:

> "We are committed to maintaining our readiness to serve the needs of our patients. Many of our employees could use their skills in languages other than English.
>
> We are compiling information about resources available within our work force. Please complete and return this survey to <department/contact> no later than <date>.
>
> This survey will not affect your performance evaluation. It is just a way for us to improve our customer service, and to make you part of such efforts.
>
> ***Thank you for your assistance."***

Once bilingual staff have been identified, **they should be referred to professional language assessment agencies** to evaluate the level of proficiency. There are many sources that will help you assess the bilingual capacity of staff.

Depending on their level of confirmed fluency, your practice would be able to make use of this added value to help your practice better communicate with your patients in the client's language of preference.

Employee Language Skills Self Assessment Key

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.

Key	Reading
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.

Key	Writing
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.

Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE SKILLS SELF-ASSESSMENT TOOL
(For Clinical and Non-Clinical Employees)

This self assessment is intended for clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English.

Employee's Name: _____ **Department/Job Title:** _____

Work Days: Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun Work Hours (Please Specify): _____

Directions: (1) Write any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language (See attached key).
(3) Specify if you currently use the language regularly as a part of your job responsibilities.

Language	Dialect, region, or country	Fluency: see attached key (Circle)			As part of your job, do you use this language to speak with patients? (Circle)	As part of your job, do you read this language? (Circle)	As part of your job, do you write this language? (Circle)
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

Please check off additional qualifications/credentials that support language proficiency level, and attach them to this form.
Note: Per state guideline, bilingual providers and staff who communicate with patients in a language other than English must identify and maintain qualifications of their bilingual capabilities on file.

- □ Formal language assessment by qualified agency
- □ Native speaker with a higher education in language, which demonstrates sufficient accuracy and vocabulary in health care setting.
- □ Documentation of successful completion of a specific type of interpreter training
- □ Documentation of years employed as an interpreter and/or translator
- □ Other (Please specify):_____

Individuals who rate themselves with speaking, reading, or writing capabilities below level 3 as defined on the Employee Skills Self Assessment Key, attached to this document, should **not use their bilingual skills or serve** as interpreters and/or translators. For assistance, please contact the patient's contracted health plan for immediate telephonic interpreter assistance.

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate. Date: _____

Section C

A Guide to Information in Section C

RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUND AND ITS IMPACT ON HEALTH CARE DELIVERY

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditi ons, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.
Cultural Background: Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.

C-01-04 (pg. 1 of 1)

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues
Surrounding the collection of sexual health histories.

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Gender roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual health and patient cultural background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. *Example: Chinese males may discuss sexual performance problems in terms of a "weak liver."* • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same gender as the patient.

C-02-04 (pg. 1 of 2)

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues Surrounding the collection of sexual health histories.

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Confidentiality preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: *"To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information."* • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

***NOTE: Avoid** using family members as interpreters. **Minors** are **prohibited** to be used as interpreters. Find an interpreter with a health care background. Make sure the request for or refusal of an interpreter is **documented** in the patient's medical chart.

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you tre at patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.

PAIN MANAGEMENT ACROSS CULTURES (continued)

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Beliefs about drug addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the medications and doses have changed.	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices. • Assure your patient you are watching their particular case.
Use of alternative pain relief treatment	• Your patient may be using traditional pain relief treatment, such as herbal compresses or teas, massage, acupuncture or breathing exercises.	• Respectfully inquire about all of the ways the patient is treating their pain. • Use indirect questions about community or family traditions for pain management to provide hints about what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods needed to assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain - scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **NOTE: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

CULTURAL BACKGROUND
Information on Special Topics

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical trea tment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked i n an accepting, non-judgmental way. This information is important for the accuracy of the c linical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating sympto ms and treating the disease.

- Some treatments and "medicines" that are considered "folk" m edicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are pur chased "at special stores" may get you a more accurate understanding of what people are using than asking about "alternative," " traditional," "folk," or "herbal" medicine.

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigm a associated with pregnancy outside of marriage. However, it is important to avoid making ssumptions about how welcome any pregnancy may be.

- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best t ool to counter any negative traditional beliefs.

- The belief that breastfeeding works as a form of birth control is very s trongly held by many new immigrants. It is important to explain to them that breastfeeding d oes not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

CULTURAL BACKGROUND – (continued)

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.

- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
  - Among traditional Hmong, saying a baby is "pretty" or "cute" ma y be seen as a threat because of fears that spirits will be attracted to the child and take it away
  - Some traditional Latinos will avoid praise to avoid attracting the "e vil eye"
  - Some Vietnamese consider profuse praise as mockery

- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."

- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immuni zations are often the most accepted form of preventive medicine. It may be helpful to exp lain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse , concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost i mportance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these prob lems.

- Gender roles are often expressed in the use or avoidance of many substan ces, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's cult ure.

- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

CULTURAL BACKGROUND – (continued)

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abu se ***not*** because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to interve ntion by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patie nts.

- Families may have members with conflicting values and rules for acceptab le behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. Thi s may cause special difficulties for teens who may have adopted new cultural values common t o Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Man y people are not very emotionally and physically expressive of physical and mental pain. Lear n about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the fa mily uses traditional home remedies.

CULTURAL BACKGROUND – (continued)

Communicating with the Elderly

- Always address older patients using formal terms of address unless you a re directly told that you may use personal names. Also remind staff that they should do the s ame.
- Stay aware of how the physical setting may be affecting the patient. Ba ckground noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal pro gnosis is unlucky or will bring death sooner and families may not want the patient to know ex actly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant o f the patient's cultural perspective. Offer the opportunity to learn the truth, at whate ver level of detail desired by the patient.
- It is important to explain the specific needs for having an advance dire ctive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than th e patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of readin g skills and may feel stigmatized by their inability to read. If you suspect this is the case you shou ld not draw attention to this issue but seek out other methods of communication .

Section D

A Guide to Information in Section D

REFERENCE RESOURCES FOR CULTURAL AND LINGUISTIC SERVICES

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provisio n of cultural and linguistic services for patients in federally funded programs are included in this section.

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Web based resources for more information related diversity and the deli very of cultural and linguistic services.

The following materials are available in this section.

Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fourteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors fro the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

Title VI of the Civil Rights Act of 1964

"No person in the United States shall, on the ground of race, color o national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding f rom the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Othe r federal and state legislation protecting the right to "equal care" outline how this principle wi ll be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, ho wever, bothe Office of Civil Rights and the Office of Minority Health have become more active i n interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Se rvices Office of Civil Rights issued "Policy Guidance on the Prohibition Against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

D-02-04 (pg. 1 of 1)

STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Below follows an informal summary of excerpts from the Office of Minorit publication entitled "Assuring Cultural Competence in Health Care: Re for National Standards and an Outcomes-Focused Research Agenda."

1	Patients/consumers must receive from all staff: effective, understandabl e, and respectful care that is provided in a manner compatible with their cultural health belie fs and practices of preferred language.
2	Strategies should be implemented to recruit, retain, and promote a diver se staff and organizational leadership that are representative of the demographic cha racteristics of the service area.
3	Staff at all levels and across all disciplines should receive ongoing education and training in culturally and linguistically appropriate service delivery.
4	Language assistance services must be offered and provided, including bil ingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner, during all hours of operation.
5	Patients/consumers must be provided verbal and written notices about the ir right to receive language assistance services; these notices must be in their language of preference.
6	Language assistance provided to Limited English Proficient (known as " LEP") patients must be provided by competent interpreters and bilingual staff. Family and frien ds should not be used for interpretation services.
7	Easily understood patient-related materials and signage must be made available/posted in languages of the commonly encountered groups represented in the service area.
8	A written strategic plan should be developed, implemented and promoted, outlining clear goals, policies, operational plans, and management accountability/oversight mec hanisms to provide culturally and linguistically appropriate services.
9	Organizational self-assessments must be conducted regarding CLAS-related activities, and cultural and linguistic competence measures should be incorporated into intern al audits, performance improvement programs, patient satisfaction assessments, and outcome-based valuations.
10	Data on race, ethnicity, and language difference should be collected in patient/consumer health records, integrated into the information management systems and updated periodically.
11	Current demographic, cultural, and epidemiological profiles of the commu nities served should be maintained, as well as needs assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service ar ea.
12	Participatory and collaborative partnerships with communities should be established and a variety of formal and informal mechanisms should be used to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13	Conflict and grievance resolution processes must be culturally and lingu istically sensitive, and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.
14	Information should be made public regularly regarding progress and succe ssful innovations in implementing CLAS standards, and inform the public and the impacted communities about the availability of such information.

D-03-04 (pg. 1 of 1)

EXECUTIVE ORDER 13166, AUGUST 2000

IMPROVING ACCESS TO SERVICES FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY]

(Verbatim)

By the authority vested in me as President by the Constitution and the l aws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their En glish proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English languag e. The Federal Government is committed to improving the accessibility of these services to eligibl e LEP persons, a goal tha reinforces its equally important commitment to promoting programs and ac tivities designed to help individuals learn English. To this end, each Federal agency shall examin e the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission o f the agency. Each Federal agency shall also work to ensure that recipients of Federal financial as sistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP pe rsons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activ ities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with t he standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and sha ll send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

D-04-04 (pg. 1 of 2)

(Cont. Executive Order 13166)

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance.Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if addi tional guidance is necessary to comply with this order. The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency sha ll submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, suc h as LEP persons and their representative organizations, recipients, and other appropriate individu als or entities have an adequate opportunity to provide input. Agencies will evaluate the partic ular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effectiv e, fiscally responsible, responsive to the particular circumstances of each agency, and can be re adily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the execut ive branch and does not create any right or benefit, substantive or procedural, enforceable at l aw or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON
THE WHITE HOUSE

Office of the Press Secretary
(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

Bibliography of Major Hard-Copy Sources Used in the Production of the Toolkit

Aguirre-Molina, M., et al. (2001). Health Issues in the Latino Community. San Francisco: Jossey-Bass.

Avery, C. (1991). Native American Medicine: Traditional Healing. JAMA, 265, 2271-2273.

Baer, H. (2001). Biomedicine and Alternative Healing Systems in America. Madison, WI: University of Wisconsin Press.

Bonder, B., Martin, L., & Miracle, A. (n.d.) Culture in Clinical Care. Thorofare, NJ: SLACK, Inc.

Carillo, J.A., Green., & J. Betancourt. (1999). Cross–Cultural Primary Care: A patient-based approach. Annals of Internal Medicine, 130, 829-834.

California Healthcare Interpreters Association & CHIA Standards and Cert ification Committee (Eds.). California Standards for Healthcare Interpreters: Ethical Principal, Protocols, and Guidance on Roles and Interventions. Oxnard, CA: The California Endowment.

Cross, T., Dennis, KW., et al. (1989). Towards a Culturally Competent System of Care. Washington, DC: Georgetown University.

Doak, C., et al. (1996). Teaching Patients with Low Literacy Skills. Philadelphia: J.B. Lippincott Co.

Duran, D., et al. (Eds.). (2001). A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics. Washington D.C.: National Alliance for Hispanic Health.

Fadiman, A. (1997). The Spirit Catches You and You Fall Down. New York: Farrar, Strauss & Giroux.

Galanti, G. (1997). Caring for Patients from Different Cultures. Pennsylvania, PA: University of Pennsylvania Press.

Goodman, A., et al. (2000). Nutritional Anthropology: Biocultural Perspectives on Food and Nutrition. Mountainview, CA: Mayfield Publishing Company.

Hall, E.T. (1985). Hidden Differences: Studies in International Communication. Hamburg, Germany: Gruner & Jahr.

Hall, E.T. (1990). Understanding Cultural Differences. Yarmouth, ME: Intercultural Press.

Harwood, A. (Eds.). (1981). Ethnicity and Medical Care. Cambridge, MA: Harvard University Press.

(Cont.) Bibliography of Major Hard-Copy Sources Used in the Production of the Toolkit

Kaiser Permanente National Diversity Council. (1999). Provider's Handbook on Culturally Competent Care. Oakland, CA: Kaiser Permanente.

Kleinman, A. (1980). Patients and Healers in the Context of Culture. Berkeley, CA: University of California Press.

Kleinman, A. (1990). Illness Narratives. New York: Perseus Publishing.

Kleinman, A., & Good, B. (Eds.). (1985). Culture and Depression. Berkeley, CA: University of California Press.

Leslie, C., & Young, A. (Eds.). (1992). Paths to Asian Medical Knowledge. Berkeley, CA: University of California Press.

Leigh, JW. (1998). Communicating for Cultural Competence. New York: Allyn and Bacon.

Lipson, J., Dibble, S., et al. (Eds.). (1996). Culture and Nursing Care: A Pocket Guide. San Francisco: UCSF Nursing Press.

O'Conner, B. (1995). Healing Traditions: Alternative Medicine and the Health Professions. Philadelphia: University of Pennsylvania Press.

Office of Minority Health, Department of Health and Human Services (200 0)Assuring cultural competence in health care: Recommendations for national standards and an outcomes focused re search agenda (Federal Register Volume 65, No. 247, pp. 80865-80879).

Office of Minority Health, Department of Health and Human Services (200 1)National standards for culturally and linguistically appropriate services in health care: Final Report.

Purnell, L.D., & Paulanka, B.J. (1998). Transcultural Health Care: A Culturally Competent Approach. Philadelphia, PA: F.A. Davis Company.

Salimbene, S. (2000). What Language Does Your Patient Hurt In? A Practical Guide to Culturally Competent Care. Northampton, MA : Inter-Face International, Inc.

Smedley, B., Stith, A., & Nelson, A. (Eds.). (2002). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press.

Spector, R. (1996). Cultural Diversity in Health and Illness: a Guide to Heritage Assessment and Health Traditions. Boston: Appleton & Lange.

Spector, R. (2000). Cultural Diversity in Health and Illness. Upper Saddle, NJ: Prentice Hall Health.

U.S. Code. (1964). Title VI of the Civil Rights Act of 1964. Title 42 - The Public Health and Welfare. 42 U.S.C. § 2000d et seq.

Walzer, J. (2002, May 2). The Health of Hispanic Elders: The Intersec tion of Nutrition, Culture and Diabetes. Tufts Nutrition.

Please refer to the "Web Resources" pages of this toolkit to find work of the Committee.

Bibliography of Major Internet Sources
Used in the Production of the Toolkit

www.ahrq.gov/about/cods: Oral, Linguistic, and Culturally Competent Services: Guides for Managed Care Plans. Agency for Healthcare Research and Quality. Rockville, MD. (2003).

www.bcbsfl.com: Blue Cross and Blue Shield of Florida. Healthy People 2010. (2002).

www.bphc.org : Culturally and Linguistically Appropriate Standards of Care. As approved by the Boston HIV Health Services Planning Council on January 11, 2001.

www.cms.hhs.gov/healthplans: Centers for Medicare and Medicaid Services. The Medicare Advantage Organization National QAPI Project for 2003. (2004).

www.cms.hhs.gov/healthplans/opl/opl133.pdf: Department of Health and Human Services Centers for Medicare & Medicaid Services. Operational Policy Letter #: OPL 2001.133. July 16, 2001.

www.erc.msh.org: Management Sciences for Health. Culturally Competent Organizations. CLAS Standards. (2003).

www.lep.gov: Department of Justice, Civil Rights Division, Executive Order 13166. Information and Guidance for Recipients of Federal Funds on Language Acc ess to Federally Assisted Programs and Activities. (2003).

www.omhrc.gov/clas: Office of Minority Health. A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropr iate Services in Health Care (December 2001).

www.usdoj.gov/crt/cor/Pubs/eolep.htm: Department of Justice, Civil Rights Division, Executive Order 13166. Improving Access to Services for Persons with Limited English Proficienc ,Verbatim as released by the Office of the Press Secretary, The White House (August 11, 2000).

Cultural Competence Web Resources

General Cultural Competence

- Resources for Cross-Cultural Health Care http://www.diversityrx.org
- Provider's Guide to Quality and Culture http://erc.msh.org/quality&culture
- HRSA http://bphc.hrsa.gov/cc/3.htm
- University of Pennsylvania Health Systems http://www.uphs.upenn.edu/aging/diverse/direct.shtml
- World Education Culture health, literacy http://www.worlded.org/us/health/docs/culture/
- National Academy Press http://books.nap.edu/books/0309071542/html/index.html
- Oregon State University http://osu.orst.edu/dept/ehe/nu_diverse.htm
- National Center For Cultural Competence, Georgetown University http://gucdc.georgetown.edu/nccc/
- National Council on Interpreting in Health Care http://www.ncihc.org
- Department of Justice – Office of Civil Rights http://www.usdoj.gov/crt/cor/13166.htm
- The State of Literacy in America http://www.nifl.gov/readers/reader.htm
- Nhelp Racial/ Cultural Issues http://www.nhelp.org/race.shtml#ling
- Office of Minority Health http://www.omhrc.gov/
- DHHS Office of Civil Rights http://www.hhs.gov/ocr/
- The Cross Cultural Health Care Program http://www.xculture.org/index.cfm
- The Plain Language Association International http://www.plainlanguagenetwork.org/
- Kaiser Family Foundation Minority Health http://www.kff.org/content/2001/6012/
- Federal Registry (enter key word "linguistic") http://www.access.gpo.gov/su_docs/aces/aces140.html
- Yale University Cultural Competence Resources http://www.med.yale.edu/library/education/culturalcomp
- Medical Policy Institute http://www.medi-cal.org/publications/
- Providing care to diverse populations http://www.ahcpr.gov/news/ulp/ulpcultr.htm
- National Institutes of Health http://www.health.nih.gov
- Culture and nutrition http://www.nal.usda.gov/fnic
- AMSA Diversity in Medicine http://www.amsa.org/div
- Center for Cross Cultural Health http://www.crosshealth.com

Aging

- Administration on Aging http://www.aoa.gov/prof/aoaprog/healthpromo/healthpromo.asp
- Culture and Aging http://www.stlcc.cc.mo.us/mc/users/vritts/aging.html
- Center on an Aging Society http://ihcrp.georgetown.edu/agingsociety/
- AARP Aging and Minorities http://www.research.aarp.org/general/portmino.html

African American

- Congress of National Black Churches http://www.cnbc.org/
- NAACP National Health Committee http://www.naacp.org/health /
- National Association of Black Cardiologists http://www.abcardio.org/
- National Black Nurses Association http://www.nbna.org/
- National Caucus and Center on Black Aged, Inc. http://www.ncba-blackaged.org/
- National Medical Association http://www.nmanet.org/

D-06-04 (pg. 1 of 2)

Cultural Competence Web Resources (continued)

American Indian/Alaskan Native

• Association of American Indian Physicians	http://www.aaip.com/
• Native American Cancer Research	http://members.aol.com/natamcan /
• National Indian Council on Aging	http://www.nicoa.org
• National Indian Health Board	http://www.nihb.org/
• Breast Cancer Survivors Network	http://members.aol.com/natamcan/network.htm

Asian American/ Pacific Islander American

• Asian & Pacific Islander American Health Forum	http://www.apiahf.org/
• Chinese American Medical Society	http://www.camsociety.org/
• National Asian Pacific Center on Aging	http://www.napca.org
• National Asian Women's Health Organization	http://www.nawho.org/"
• National Resource Center on Native American Aging (Native Hawaiian)	http://www.und.nodak.edu/dept/nrcnaa/

Hispanic/Latino American

• Hispanic Center for Excellence UI Chicago	http://uic.edu/depts/mcam/hce
• Inter-American College of Physicians and Surgeons	http://users.rcn.com/icps
• National Alliance for Hispanic Health	http://www.hispanichealth.org/
• National Association of Hispanic Nurses	http://www.nahnhq.org
• National Council of La Raza	http://www.nclr.org
• National Hispanic Council on Aging	http://www.nhcoa.org
• National Hispanic Medical Association	http://home.earthlink.net/~nhma/

Remember- web can pages expire often. If the web address provided does not work use Google and search under the organization's name.

Acknowledgements

The ICE for Health Cultural and Linguistic Work Group would like to ackn owledge the individuals listed below for the knowledge they shared in the creation of the materials for the t ool kit. Each member contributed their time, experience and skills to the process of developing and testing the resources co ntained in this kit.

Peggy Payne MA, CDE
ICE C&L Chair,
Editor coordinator/team
Director of Diversity & Mbr.Ed.
SCAN Health Plan
Long Beach CA 90801

Diana Carr, MA
Tool Kit Work Group Chair,
Editor coordinator/team
Cultural and Linguistic Specialist
Health Net of California, Inc.
Pasadena, CA 91106

Nhu-Hao T. Duong, MBA
Tool Kit Team Lead
Director, Customer Service
CalOptima
Orange, CA 92868

Janie Tyre MPA
Tool Kit Team Lead
VP Marketing and Mbr. Services
Santa Clara Family Health Plan
San Jose, CA

Regina Ziashari, MPH, CHES
Tool Kit Team Lead
Cultural & Linguistics Specialist
Care1st Health Plan
Alhambra, CA 91803

Margie Akin, PhD
Editor team
Cultural and Linguistic Specialist
Molina Health Care, Colton, CA
Associate Research Anthropologist
University of California, Riverside

Claudia Brauer
Editor team/layout
Senior Quality Compliance Analyst
Blue Cross and Blue Shield of Florida
Miami, FL 33122

Amy Bussian Bennett
Director, Medicare/Medicaid
Blue Cross and Blue Shield Association
Chicago, IL 60601

Smita S.Dandekar
Clinical Research Manager
Blue Cross of California
Woodland Hills, CA. 91367

Sandi Deckinger, MPA. RN
Quality Assessment Director
Chinese Community Health Plan
San Francisco, CA 94133

Lee Kervin
C&L Program Specialist
Blue Cross of California
Camarillo, CA 93012

Lisa M. Kregel, MBA,
Manager, Geriatric Research &
Health Ed.
Dep. of Healthcare Informatics
SCAN Health Plan
Long Beach CA 90801-5616

Elizabeth Le
Editor team
Manager, Customer Service
CalOptima
Orange, CA 92868

Jerilou Livingston
Independence Blue Cross,
Philadelphia
Philadelphia, PA 19103

Gloria Orellana, MPH
Manager of Health Ed. and
C& L Services
Universal Care
Signal Hill, CA 90755

Sunny Pak
Project Manager
National L&C Programs
National Diversity
Kaiser Permanente
Oakland, CA 94612

Susana Razo MPA,
Health Education &
Cultural and Linguistic Manager
Santa Clara Family Health Plan
San Jose, CA

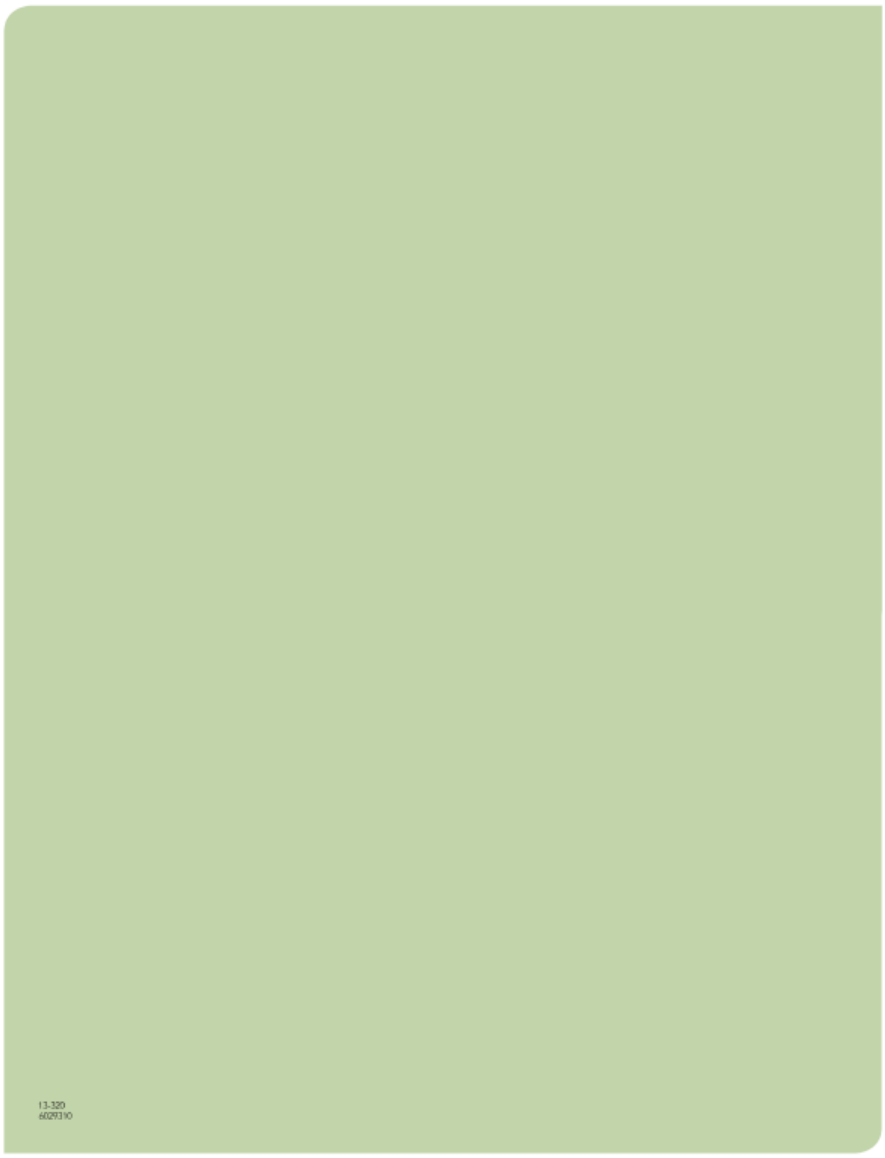
Silvana Ricci RN, BA HSA, CPHQ,
Quality Improvement Specialist
Santa Clara Family Health Plan
San Jose, CA

Nancy Rodriguez, BSN, RN,
CPHQ, PAHM – Sr. Quality Mgmt.
Compliance Specialist
Blue Cross Blue Shield of Georgia
Atlanta, GA 30326

Philip Smeltzer
HealthNow NY
Buffalo, NY 14240

Tina Vu
Senior Health Education/C&L
Coordinator
UHP Healthcare
Inglewood, CA 90303

Nancy C. Walker
Manager, QI
Blue Cross of California
Walnut Creek, CA 94596



Language Assistance Services

Found in: Operations Manuals > Quality Improvement Effective 07/21/2016

As required under federal regulations, Health Net Access provides no-cost language assistance services to members. Health Net Access provides the following in order to comply with mandated cultural and linguistic appropriateness standards:

- Telephone interpreter services for medical appointments.
- Sign-language services for medical 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.

All Health Net Access hearing impaired members can contact the Health Net Customer Contact Center by using 711 and giving the relay operator Health Net Access Customer Contact Center toll free number.

Requirements

Health Net Access participating providers are required to support language assistance services by complying with the following:

- Interpreter services - Use qualified interpreters for limited-English proficient (LEP) members. Telephonic interpreter services are provided by Health Net Access at no cost to providers or 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. Health Net Access strongly discourages the use of family, friends or minors as interpreters. If, after being informed of the availability of no-cost telephonic interpreter

services, the member prefers to use family, friends or minors as interpreters, the provider must document this in the member's medical record.

Interpreter Services

Information regarding telephonic interpreter services is available by contacting the Health Net Access Member Services. When calling, the following information is required:

- Member name
- Member Health Net Access ID number
- Appointment date and time, if necessary

For more information about how to work with an interpreter, refer to the Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations.

Cultural Competency Training

Health Net Access recommends that all providers participate in a cultural competency training course as part of their continuing education. The HHS' Office of Minority Health (OMH) offers a computer-based training (CBT) on cultural competency for health care providers. This program was developed to furnish providers with competencies enabling them to better treat the increasingly diverse population. For more information, refer to the OMH Think Cultural Health website.

Providers who would like information about topics such as cross-cultural communication, health literacy or accessing interpreter services, may contact Health Net's Cultural and Linguistic Services Department .

Medical Record Documentation

Found in: Operations Manuals > Quality Improvement Effective 05/16/2016

In accordance with Health Net Access Quality Management (QM) policies, providers are responsible to ensure that complete and accurate content and confidentiality of members' medical records is maintained. Health Net Access requires its providers to maintain current, organized and detailed clinical records in order to permit effective and confidential patient care. These records must be consistent with standard medical and professional practice. All protected health information (PHI) must be handled in accordance with established policies and procedures, and federal and state regulations, in order to safeguard patient confidentiality. Health Net Access requires that providers safeguard the confidentiality of those records and member information in accordance with applicable laws.

Health Net Access QM policies also establish basic standards for the administration of clinical records and medical record documentation requirements for providers in order to ensure quality care and service are provided to enrolled Health Net Access members. Primary care providers (PCPs), obstetricians/gynecologists (OB/GYNs), pediatricians, high-volume specialists, dentists, and medical groups are required to maintain a legible clinical record for each Health Net Access member who has been seen for medical and dental appointments or procedures, or has received medical/ behavioral health/dental records from other providers who have seen the member. Organizational providers are also required to maintain a comprehensive medical record for each enrolled Health Net Access member as appropriate. The record must be up-to-date, well organized and comprehensive with sufficient detail to promote effective patient care and quality review. The Health Net Access QM Department has implemented a process for monitoring contracting providers' medical record documentation to ensure compliance with established AHCCCS and Health Net Access standards. PCPs, OB/GYNs, pediatricians, high-volume specialists, dentists, and medical groups are included in the monitoring process.

Performance Improvement Projects

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

The Health Net Access' Quality Management (QM) program participates in Arizona Health Care Cost Containment System (AHCCCS)-mandated Performance Improvement Projects (PIPs) on topics that take into account comprehensive aspects of members' needs, care and services. In addition, the QM Department may select and design, with AHCCCS approval, additional PIPs that are specific to members' needs and identified through internal monitoring of data for trends. Selected PIP topics take into account comprehensive aspects of member needs, care and services for a broad spectrum of members, or focused subset of the AHCCCS population. PIPs include measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Clinical focus topics for PIPs may include:

- Primary, secondary and/or tertiary prevention of acute conditions.
- Primary, secondary and/or tertiary prevention of chronic conditions.
- Care of acute conditions.
- Care of chronic conditions.
- High-risk services.

- Continuity and coordination of care.

Non-clinical focus topics may include:

- Availability, accessibility and adequacy of the service delivery system.
- Cultural competency of services.
- Interpersonal aspects of care (such as quality of provider/member encounters).
- Appeals, grievances and other complaints (such as quality of care).

For each PIP, Health Net Access assesses performance using indicators that are objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Interventions are implemented to improve performance, based on an evaluation of barriers to care or use of services, and an evidence-based approach to improving performance, as well as any unique factors of Health Net Access membership, provider network or geographic area served. Health Net Access reports interventions, analysis of interventions, internal measurements, changes or refinements to interventions, as well as any actual or projected results annually to AHCCCS as required.

Quality Improvement Referrals

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

Health Net Access members, associates, participating providers, and community citizens may make written or verbal referrals to the Health Net Access Quality Management (QM) Department when a suspected or identified problem exists in the delivery of health care to a member by a Health Net Access provider.

Potential quality of care issues include preventable and avoidable conditions, delays in obtaining treatment, surgical complications, morbidity or mortality, and poor medical record documentation.

The QM Department documents and tracks all QM referrals. The QM Referrals Report documents the type of concern, severity, provider involved, and outcomes. Health Net Access medical directors make the final determinations on whether referrals are presented to the Peer Review Committee for further discussion or action (Health Net Access complies with federal law 42 U.S.C. 1112 and Arizona Statute A.R.S. 36-2404, which provides for confidentiality of peer review and regulatory agency information).

Reports specific to a provider are included as part of the recredentialing process.

Quality of Care Issues

Found in: Operations Manuals > Quality Improvement Effective 05/18/2016

In compliance with regulatory requirements, Health Net Access monitors and evaluates potential quality issues (PQIs) involving Health Net Access members. Use the Potential Quality Issue (PQI) Referral form to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation.

The Health Net Access Quality Management (QM) program monitors and reports performance and processes related to the quality of care and services provided. QM program policies have established standards for both the quality and safety of clinical care and service delivery for enrolled members. All Heath Net Access contracting providers are required to report to the appropriate regulatory agency, such as Adult Protective Services (APS) or Arizona Department of Child Safety (DCS), and to the Health Net Access QM Department any suspected incidences of member abuse, neglect, exploitation, or unexpected death as soon as they become aware of the incident. The QM program monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QM program also supports the identification and pursuit of opportunities, based on input from affiliated providers and members, to improve health outcomes, the continuum of care, and both member and provider satisfaction.

Referrals

Found in: Operations Manuals Effective 01/01/2003

Behavioral Health Referral

Found in: Operations Manuals > Referrals Effective 10/01/2015

Primary care physicians (PCPs) may provide outpatient behavioral health services for select behavioral health diagnoses, including attention deficit hyperactivity disorder (ADHD), depression and anxiety within the scope of their practice. PCPs must coordinate referrals for members requiring specialty or inpatient behavioral health services through Health Net Access for members eligible for both Medicare and Medicaid. For Medicaid-only members, PCPs must coordinate referrals for behavioral health services with the Regional Behavioral Health Authority (RBHA)/Tribal RBHA (TRBHA) system. Tribal members and veterans retain choice in

where they access all or part of their care, including through Indian Health Services/638 facilitates or the Veterans Administration. Refer to the Behavioral Health section for additional information.

Referrals to Specialists

Found in: Operations Manuals > Referrals Effective 07/01/2013

Most specialty services can be provided by Health Net participating specialists. When making a referral, the following guidelines apply:

- If a member requires specialty services, available specialists in the medical group/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's entire network may be available to the member; however, prior authorization is required
- The primary care physician (PCP) must also take into consideration input from the member regarding proposed treatment plans

If Health Net's network of specialists cannot perform the services required, prior authorization is required to refer outside Health Net's network.

Providers may complete the Health Net Referral Form or use their own forms or script to facilitate the referral process.

Role of the Primary Care Provider

Found in: Operations Manuals > Referrals Effective 05/17/2016

The primary care provider (PCP) is responsible for providing or ensuring the provision of comprehensive first contact and continuing covered primary care services for Health Net Access members and supervising preventive, acute and chronic health care for those members. These services include, at a minimum, the treatment of routine illness, maternity services if applicable, immunizations, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for eligible members under age 21, adult health screening services, and medically necessary treatments for conditions identified in an EPSDT or adult health screening. This responsibility includes initiating, supervising and coordinating referrals for specialty care inpatient and skilled facilities, home health care and similar services. Generally, PCPs are expected to understand and coordinate the total course of their patients' care and ensure continuity in their care. The PCP must also take into consideration input from the member regarding proposed treatment plans. In this way, the PCP serves a critical role in helping the member obtain the highest coverage levels available.

PCPs in their care coordination role serve as referral agents for specialty treatments and services provided to Health Net Access members assigned to them, and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to providers or hospitals within the Health Net Access network, as appropriate, and if necessary, referring members to out-of-network specialty providers.
- Coordinating with Health Net Access for prior authorization procedures for members.
- Conducting follow-up for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals, including maintenance of records of services provided in the members' medical records.
- Coordinating medical care of Health Net Access members assigned to them, including, at a minimum:
    - Oversight of medication regimens to prevent negative interactive effects.
    - Follow-up for all emergency services.
    - Coordination of inpatient care.
    - Coordination of services provided on a referral basis.
    - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

The PCP must maintain medical records, including records on preventive care, past medical treatment, past and current health status, and treatment plans for the future in the member's medical record. When initiating a referral to a specialist, it is the referring physician's responsibility to forward all pertinent information to the specialist for the referral. In order to promote continuity of care, the PCP must also have on record all treatment, examination and results performed by other physicians or clinicians, including service dates. Summaries are acceptable in lieu of complete chart notes.

Role of the Specialist

Found in: Operations Manuals > Referrals Effective 05/17/2016

Primary care providers (PCPs) must provide a written referral for a member to receive services from a specialist, Coverage is not available for services rendered to a member by a specialist unless the member has a written referral from the member's PCP (except for services for which a member may self-refer. The referral allows for a specialist to provide an initial consultation, in-office treatment and follow-up care. The PCP is responsible for

coordinating the specialist referral and must forward all pertinent information to the specialist for the referral.

If the member needs to be referred to another physician for the same medical condition, the specialist may refer the member to another in-network specialist or may contact the member's PCP for assistance.

The PCP must maintain a record of treatment, examination and results performed by other physicians or clinicians, including service dates in the member's medical record. Treatment plans, follow-up needs, any complications, and prescribed medications must be included. Summaries are acceptable in lieu of complete chart notes.

Self-Referral Benefits

Found in: Operations Manuals > Referrals Effective 05/17/2016

Members may self-refer to a specialist or may request the assistance of the primary care provider (PCP) for the following services (subject to benefit limitations)

- Behavioral health care.
- OB/GYN for annual Pap smear and pelvic examination.
- Dental services (children under age 21).
- Emergency services.

Members must receive these self-referral services from a Health Net Access participating provider who is registered with the Arizona Health Care Cost Containment System (AHCCCS). The member must work with his or her PCP to receive referral and authorization to an out-of-network provider when there is no Health Net Access participating provider available that can provide these services.

The PCP should inquire about all services a member has received in order to facilitate a complete medical record for the member.

Standing Referrals

Found in: Operations Manuals > Referrals Effective 07/01/2013

Health Net is required to have and follow a procedure by which a member may receive a standing referral to a specialist. Standing referrals are referrals by a primary care physician (PCP) to a specialist for more than one visit without the PCP having to provide a specific referral for each visit. A treatment plan may limit the number of visits to the specialist, limit the period of time for which the visits are authorized, and require that the specialist provide the PCP regular reports on the health care provided to the member.

Third Party Liability

Found in: Operations Manuals Effective 01/01/2003

Overview

Found in: Operations Manuals > Third Party Liability Effective 07/01/2013

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 *Evidence of Coverage (EOC).* If the member is entitled to recovery, Health Net 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
- Tort feasors, including casualty
- Restitution recovery
- Special treatment trust recovery

Provider and Member Responsibilities

Found in: Operations Manuals > Third Party Liability Effective 07/01/2013

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 with the information using the Authorization to Treat a Health Net Member form or other correspondence. The participating provider must continue to provide benefits in accordance with the *Evidence of Coverage.*

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 pays for claims denied by the employer's industrial insurance carrier if all of the following occurs:

1. A copy of the denial is sent with the claim to Health Net.
2. All Health Net authorization requirements have been met.
3. 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 as usual, giving all details regarding the injury or illness. Health Net pays usual benefits and may then file a lien for reimbursement from the responsible party when permitted under law.

Member Responsibilities

An injured member entitled to recovery is required to:

- Inform Health Net and participating providers of the name and address of the third party, if known, the name and address of the member's attorney, if using a attorney, and describe how the injuries were caused
- Complete any paperwork that Health Net or the participating providers may reasonably require to assist in enforcing the lien
- Promptly respond to inquiries from the lien holders about the status of the case and any settlement discussions
- Notify the lien holders immediately upon the member or the member's attorney receiving any money from the third parties or their insurance companies
- Hold any money that the member or the member's attorney receives from the third parties or their insurance companies in trust, and reimburse Health Net and the participating providers for the amount of the lien as soon as the member is paid by the third party

Utilization Management

Found in: Operations Manuals Effective 01/01/2003

Avoidable Admissions

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

An avoidable admission is broadly defined as a hospital admission that may not have occurred had the patient received timely coordinated and appropriate ambulatory care. An avoidable admission is categorized as an admission to an inpatient level of care that could have been appropriately managed at an alternative level of care. Health Net uses national criteria in determining whether an admission could have been avoided. Examples of avoidable admissions include hospitalizations for immunizable conditions, asthma, gastroenteritis, dehydration, ear nose and throat (ENT) conditions, and kidney or bladder infections.

An impacted inpatient day is defined as an additional inpatient day resulting from a delay in treatment, discharge or other service delay. An avoidable admission may result in denial of payment to the practitioner or facility.

Case Management

Found in: Operations Manuals > Utilization Management Effective 05/24/2016

Health Net case management functions operate according to Case Management Society of America standards. Health Net case managers, or delegated medical group assure that potential medically catastrophic cases are managed in cooperation with the member's primary care physician (PCP) to achieve optimum care and coverage benefits for the member. Case manager provide assistance by working with members, caregivers, physicians, and the Health Net Claims Department.

The following referral criteria are used for case management:

- Lack of an established or ineffective treatment plan - for example, a member with multiple providers and multiple services who continues to use the emergency room or continues to have multiple admissions for the same conditions
- Over-, under- or inappropriate utilization of services - for example, a member who inappropriately over-utilizes emergency room services, or who does not have an established PCP or specialty care provider, when appropriate
- Permanent or temporary alteration of functional status - for example, a member with a hip replacement who is discharged with no home support or is unable to get to medical appointments and/or physical therapy
- Medical/psychosocial/functional complications - for example, an elderly member with multiple medical conditions (comorbidity) and depression who is unable to manage activities of daily living, medications and diet
- Barriers to receiving appropriate care within the system - for example, a newly diagnosed cancer patient who has been educated by coaches, but who would also benefit from coordination of care services through Health Net's case management
- Nonadherence to treatment or medication regimens or missed appointments - for example, a member with transportation needs who is unable to get to physician appointment, or who has transportation or financial barriers to filling medication prescriptions
- Compromised patient safety - for example, an elderly member, post hip replacement, who lives on the second floor requires home evaluation for safety concerns
- High cost injury or illness - for example, a member in a severe motor vehicle accident with multiple injuries would require coordination of and authorization for multiple services for an extended period of time
- Lack of family or social support - for example, a post-operative member with wound care, but without family support to assist with dressing needs
- Lack of financial resources to meet health needs - for example, a member requiring extensive wound vacuum services but who has exhausted benefits, or a senior member who needs transportation, home help or other noncovered items
- Transition of care - for example, a new member who needs assistance in coordinating services or interpreting benefits beyond the assistance available through Health Net Member Services
- Exhaustion of benefits - for example, a member with medical necessity for a specialized hospital bed, but the member's durable medical equipment (DME) benefit is exhausted
- Member asks to speak with a Health Net nurse or case management - for example, a member who requests evaluation for case management services or assistance in coordinating services or obtaining medications
- Pregnant women at risk - for example, a woman who is pregnant with triplets, has hyperemesis, is at risk for premature delivery, or is over age 45
- Non-urgent behavioral health referrals - for example, suspected reports of substance abuse, neglect, physical abuse, and/or depression

Physicians should complete a Health Net Case Management Referral Form for commercial/Medicare members or Health Net Access members to facilitate a member considered for case management, or contact the Case Management Department (commercial/Medicare or Health Net Access) for referrals and additional information.

Concurrent Review

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

Concurrent review is the process of reviewing an inpatient stay at admission and throughout the stay to determine the medical necessity for an inpatient level of care utilizing appropriate resources, level of care and service according to professionally recognized standards of care, such as McKesson's InterQual® Severity of Illness, Intensity of Service criteria. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care. Concurrent review is initiated upon notification to the Health Net Hospital Notification Unit that a member has been admitted (in the case of an urgent or emergency admission). Concurrent review includes, but is not limited to:

- Quality of care
- Plan of treatment
- Severity of illness
- Intensity of service
- Treatment plan
- Length of stay
- Level of care
- Discharge plan

Based on the concurrent review process, the hospital stay is approved or denied. If the stay is approved, the hospital receives an authorization tracking number. The authorization tracking number must be indicated on the billed hospital claim to Health Net.

All potentially nonapproved services identified by the Health Net concurrent review nurse are reviewed with a Health Net medical director or a specialty advisor. Physicians and members have the right to appeal denied services.

Continuity of Care

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

Continuity of care refers to the system of directing and monitoring a member's care among multiple health care providers, encounters, and procedures so that the member receives timely, medically necessary health services without interruption.

The system comprises several procedural components that are required to the extent of the severity of the member's health condition. Primary care physicians (PCPs) must adhere to the following basic procedures to maintain continuity of care:

- Documentation of member encounters, missed appointments, extensions of appointment waiting time (noted that a longer waiting time for appointment will not have a detrimental impact on the health of the member), and referrals in members' medical record
- Referring members who need specialty health services
- Forwarding summaries of pertinent medical findings to specialists
- Documentation of services provided by a specialist in the member's primary care medical record
- Monitoring members who have ongoing medical conditions
- Notifying Health Net of member referrals to specialists, care management or public health programs

Additional procedures are required of PCPs when members' health conditions require urgent, emergency or inpatient health services, including:

- Documentation in members' medical record of emergency and urgent medical care and follow-up
- Coordinated hospital discharge planning
- Post-discharge care

Health Net suggests that each provider develop protocols to maintain continuity of care. A log system for tracking prior authorizations, referrals to specialists, follow-up of missed appointments, and acknowledgment and verification of such things as lab and X-ray findings is recommended. The system can be manual or computerized.

Definition of Medical Necessity

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

Medically necessary services or medical necessity is defined as health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas, and any other relevant factors

Preventive care may be medically necessary, but coverage for medically necessary preventive care is governed by the terms of the *Provider Participation Agreement* (*PPA*) and the member's *Evidence of Coverage* (*EOC*).

When considering whether a service or treatment is experimental or investigational, if such service or treatment is medically necessary, as defined above, the service or treatment is paid for unless specifically excluded from Health Net coverage.

Hospital Discharge Planning

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

The Health Net Concurrent Review Department collaborates with inpatient facilities in appropriate and timely discharge planning for Health Net members, including post-hospital care. The admitting physician is responsible for all aspects of the member's medical care, including making the determination regarding the appropriateness of discharge and post-hospitalization services.

Each hospital must have a written discharge planning policy and process that includes, but not limited to:

- Counseling for the member or family members to prepare them for post-hospital care, if needed
- A transfer summary accompanying the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital
- Information regarding durable medical equipment (DME)
- Reconciliation of discharge medications with medications the member was taking prior to admission
- Providing member with each medication dispensed upon discharge
- Making a post-discharge follow-up call to ensure members' needs are met

The concurrent review nurse is available to assist with authorization for post-discharge services.

Medical Policy Development and Evaluation of Medical Technologies

Found in: Operations Manuals > Utilization Management Effective 01/01/2013

As part of Health Net's quality assurance and utilization management programs, Health Net's National Medical Policy Unit reviews published scientific literature pertaining to the efficacy and safety of existing and emerging technologies or new uses of existing technologies. The Medical Policy Unit prepares proposed draft utilization review guidelines (national medical policies) designed to assist Health Net medical directors in making utilization review determinations relevant to the effectiveness and appropriateness of medical technology, including a service, procedure, device, medication, technique, or biological. This determination is based upon the principles of evidence-based medicine and a review of currently available clinical information from peer-reviewed published medical literature, the regulatory status of the technology, public health and health research agencies, guidelines and positions of leading national health professional organizations, views of expert physicians practicing in relevant clinical areas, and other factors. Health Net may revise these policies as new clinical information becomes available.

Health Net evaluates medical technologies based upon principles of evidence-based medicine. Results of multicenter, randomized, prospective clinical trials published in peer-reviewed medical literature that show the treatment to be at least as effective or more effective as other established modalities of therapy and/or to be associated with fewer adverse effects are considered the most scientifically rigorous evidence. Factors that are taken into account during the evaluation process include, but are not limited to:

- Whether the procedure, device, medication, technique, or biological has final approval from the appropriate governmental regulatory bodies
- Whether peer-reviewed scientific evidence is sufficient to permit conclusions about the effect of the technology on health outcomes
- Whether the technology is capable of demonstrating improvement in overall health outcomes
- Whether the technology is at least as beneficial as any established alternatives
- Whether the improvement demonstrated is attainable outside of investigational settings
- Whether specific clinical situations can be identified under which the technology will be used
- Decisions are based on safety, efficacy and effectiveness

In addition to available evidence, policy decisions are also based on established nationally accepted governmental and professional society recommendations, as well as other recognized sources. Examples include Hayes, Inc. Technology Assessments, InterQual® criteria and the Food and Drug Administration (FDA). If relevant, information from manufacturers about procedures and training issues may be considered.

Health Net's national medical policies are provided to Health Net's National Medical Advisory Council (MAC), which reviews proposed policies and revises, rejects or approves them. MAC's membership consists of a clinically and geographically diverse group of Health Net medical directors and medical management team representatives. Final approved national medical policies are made available to participating providers through the Health Net website.

Health Net's national medical polices are developed to assist in administering plan benefits; however, they do not constitute a description of plan benefits nor can they be construed as medical advice. They represent a determination of whether or not certain services or supplies are considered cosmetic, medically necessary or appropriate, or experimental and investigational. The policies do not constitute authorization or guarantee coverage for a particular procedure, device, medication, service, or supply. In the event a conflict of information is present between a medical policy, legal and regulatory mandates and requirements, and any Health Net plan document under which a member is entitled to covered services, the plan document and regulatory requirements take precedence. Plan documents include, but are not limited to, subscriber contracts, summary plan documents and other coverage documents prepared by Health Net.

For Medicare Advantage members, Health Net provides coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare and

that are available to beneficiaries residing in the plan's service area. Health Net complies with CMS' National Coverage Determinations (NCD), general coverage guidelines included in original Medicare manuals and instructions, and written Local Coverage Determinations (LCD), coverage decisions of local Medicare contractors, with jurisdiction for claims in the geographic area in which services are covered under the MA plan. In some instances, however, a Medical Advisory Contractor (MAC) outside of Health Net's service area may have exclusive jurisdiction over a Medicare-covered item or service and processes all claims for a particular Medicare-covered item or service for all Medicare beneficiaries around the country. This generally occurs when there is only one supplier of a particular item, medical device or diagnostic test, such as certain pathology and lab tests furnished by independent laboratories. In these situations, MA plans must follow the coverage requirements or LCD of the MAC that enrolled the supplier and processes all of the Medicare claims for that item, test or service.

Notification of Admissions

Found in: Operations Manuals > Utilization Management Effective 10/01/2015

To notify Health Net of an urgent or emergent inpatient and outpatient observation admissions and skilled nursing facility (SNF) admissions, providers must contact Health Net's Hospital Notification Unit within 24 hours of admission, the next business day or as outlined in the *Provider Participation Agreement* (*PPA*). Elective inpatient admissions require authorization from the Health Net 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 Hospital Notification Unit.

Notify Health Net of a newborn within 24 hours or no later than three days of delivery, by contacting the Health Net Hospital Notification Unit.

When reporting inpatient admissions, the following information is required:

- facility name
- name of caller reporting admission
- telephone number of caller reporting admission
- member's full name
- member's Health Net identification (ID) number
- 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 (elective, direct, urgent, or 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 member during the facility stay. When notifying Health Net of a newborn admission, identify the admitting pediatrician.)
- other insurance if Health Net is not primary carrier
- status of admission (inpatient, skilled nursing or sub-acute rehabilitation)

Services denied for late or non-notification are considered non-reimbursable and cannot be billed to the member.

Notification Process

Found in: Operations Manuals > Utilization Management Effective 10/01/2015

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

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

Services may be reviewed 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.

Retrospective Review

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

Retrospective review is review of the quality and medical necessity of services after care has been rendered. Retrospective professional review involves an evaluation of services that fall outside Health Net's established guidelines for coverage. These claims are reviewed by Health

Net's professional review specialists (registered nurse reviewers) and a Health Net medical director or a specialty advisor where the initial reviewer recommends that a claim be denied for lack of medical necessity.

Separation of Medical Decisions and Financial Concerns

Found in: Operations Manuals > Utilization Management Effective 07/24/2009

Medical decisions regarding the nature and level of care to be provided to a member, including the decision of who renders the service (for example, primary care physician (PCP) instead of specialist or in-network provider instead of out-of-network provider), must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization management (UM) decisions are, therefore, made by medical staff and are based solely on medical necessity. Providers may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. Health Net requires that each medical group and hospital's UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions, and that each member of the medical group's UM staff sign an acknowledgment of this. Failure to comply may result in withdrawal of delegated UM and ultimately, termination of the *Provider Participation Agreement (PPA)* with Health Net.

Specialist Reports

Found in: Operations Manuals > Utilization Management Effective 07/01/2013

Specialists are required to submit a written report to the referring physician. This written report must include the specialist's findings, recommended treatment, results of any studies, tests, procedures, and recommendations for continued care. The primary care physician (PCP) must receive the report within two weeks of the member's visit with the specialist. Emergency care reports or findings must be called to the PCP within 24 hours or by the next business day.

The PCP is required to review the specialist's findings to determine whether follow-up care is medically necessary. The PCP is responsible for directing all member care through the referral process.

Services Received in an Alternate Care Setting

Alternative care settings must send the member's PCP the following:

- Report with findings, recommended treatment and results of treatment for services performed outside the PCP's office
- Emergency department reports, hospital discharge summaries and other information
- Home health care agencies treatment plans after an authorized evaluation visit and every 30 days afterward for review of home health care and authorization
- Reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action

Utilization/Care Management Program

Found in: Operations Manuals > Utilization Management Effective 05/16/2016

Health Net Access' Utilization/Care Management program is designed to manage the use of resources to maximize the effectiveness of care provided to members. The program involves pre-service, concurrent and post-service evaluation of utilization of health services and assessment of utilization practices. The program requires cooperative participation of Health Net Access, participating medical and behavioral health practitioners, delegates, hospitals, and other providers to ensure a timely, effective and medically sound program. It is structured to ensure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence of Health Net Access management or concerns for the plan's fiscal performance. The model is patient-centric and when members actively work with a case manager, it empowers members with knowledge that allows them to become more active participants in health care decisions.

The Utilization/Care Management program is designed to promote fair, safe and consistent utilization management decision-making. The program is under the clinical supervision of Health Net Access' chief medical officer, who has substantial involvement in developing and implementing the program. It is updated as necessary and evaluated and approved annually by the Health Net Access Medical Management/Utilization Management Committee (MM/UM).

Pre-service, concurrent review and post-service review components are conducted, as applicable, in accordance with the type of service and the member's clinical condition. Health Net Access clinical associates, or delegates, conduct utilization management reviews in collaboration with Health Net Access medical directors. Non-emergency services provided outside the network receive concurrent or post-service review.

The objectives of the Utilization/Care Management program are to:

- Ensure that members have equitable access to care across the network.
- Ensure that qualified health professionals using appropriate clinical information and criteria sets make appropriate utilization management decisions.
- Establish standards for the timeliness of utilization management decision-making and operate within the standards established by the Centers for Medicare and Medicaid

Services (CMS), Department of Insurance (DOI) and the National Committee for Quality Assurance (NCQA), as applicable.

- Ensure that the reasons for each denial are clearly documented and communicated to members and practitioners, as stated within policy and procedure guidelines.
- Establish processes to monitor and oversee utilization of high-risk and high-cost procedures and services.
- Develop and update written guidelines and criteria based on sound clinical evidence and ensure that policies and procedures for applying these criteria are appropriate. Ensure that current technology and scientific evidence is used in the utilization review decision.
- Develop and implement processes and tools for transition of care, case management, continuity of care, discharge planning, and other utilization management functions to improve efficiency, continuity of care and standardization of application.
- Monitor utilization of select services against benchmarks and provide feedback to improve providers' knowledge of current medical evidence to enable providers to measure their own effectiveness to benchmarks.
- Establish processes to collect and periodically monitor data, implement interventions and measure results of the interventions for effective strategies to achieve appropriate utilization.
- Identify and intervene when quality of care issues are identified individually or through delegates' utilization management review of over- or under-utilization.
- Review over- or under-utilization thresholds and metrics.
- Comply with all applicable federal and state laws, regulations and accreditation requirements.
- Maintain and improve the health status of members with chronic conditions through development of nationally consistent clinical programs for identification and management of members.